

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 3 7 7 9			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Edward George		ANDERSON						May 6, 1980					11:24 P
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
male		white		September 21, 1904		75		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Washington						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Washington County Hospital				light plant							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		124 Broadway					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
John T. Anderson		Daisy Miller											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No				Hazel R. Anderson, Hagerstown, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary occlusion										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		20 minutes	
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Atherosclerotic heart disease										7 yrs.			
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Arteriolar nephrosclerosis. Osteoarthritis. Hypertensive cardiovascular disease													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22. I certify that (I) (this hospital) attended the deceased from May 6, 1980, to May 6, 1980, that (I) <del>xx</del> last saw the deceased alive on May 6, 1980, and that in (my) <del>xx</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>xx</del> did <del>not</del> view the body after death.													
22a. SIGNATURE		DEGREE		22b. DATE SIGNED									
W. T. Layman, M.D.				5/7/80									
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS											
		301 E. Antietam St., Hagerstown, MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
burial		May 9, 1980		Rose Hill Cemetery		Hagerstown, Wash., Maryland							
24. FUNERAL DIRECTOR		NAME		ADDRESS		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
MINNICH FUNERAL HOME		415 E. Wilson Blvd., Hagerstown, Md. 21740				MAY 12 1980		L. J. McCreedy					

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W. J. Jones

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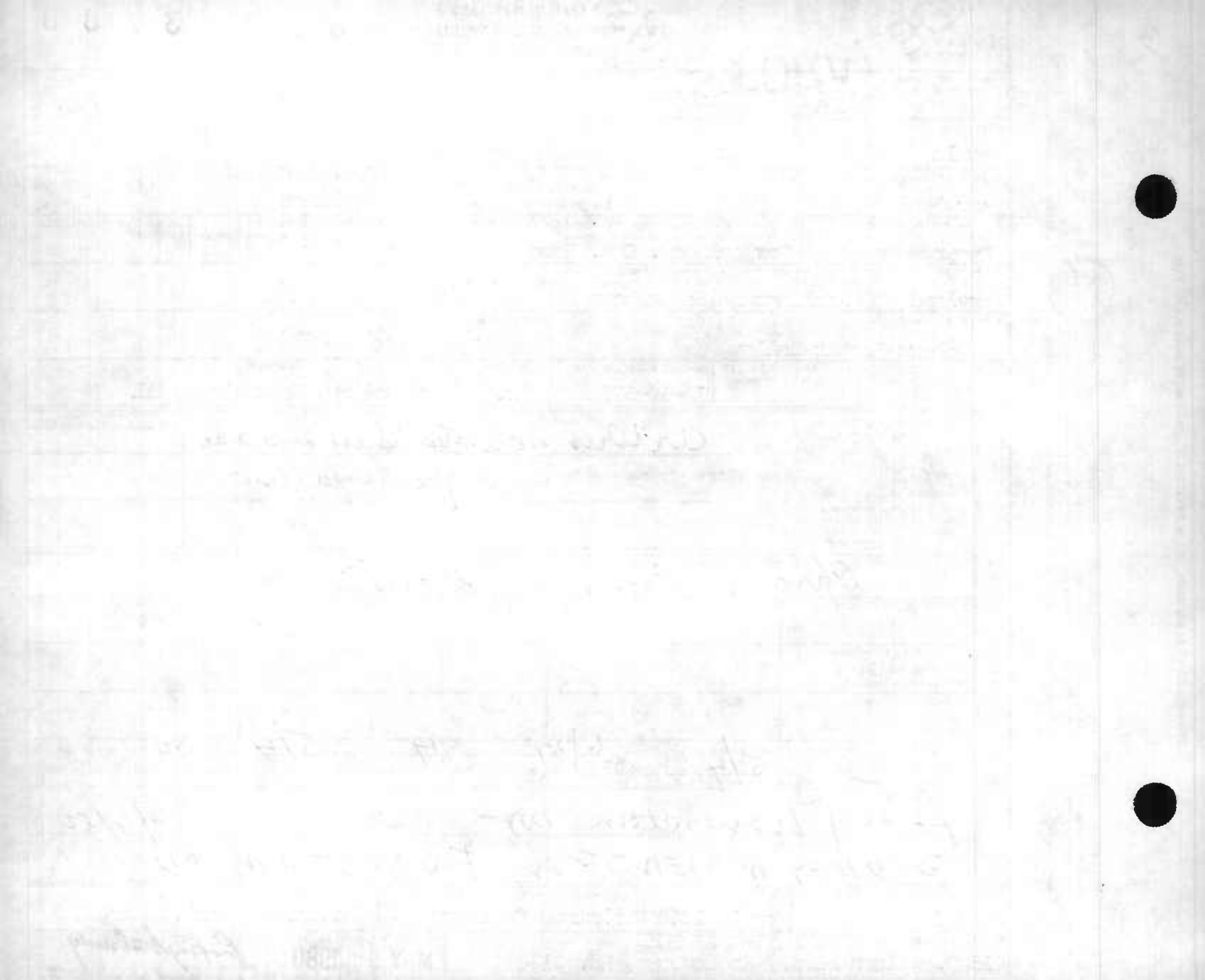
FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 3 7 8 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Clyde Elridge BAILEY			2a. DATE OF DEATH MONTH DAY YEAR May 4, 1980			2b. HOUR 11:20 A.M.			
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR November 21, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garlock Mem. Con. Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) teacher		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 9	
14 FATHER'S NAME FIRST MIDDLE LAST Robert Lester Bailey					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosalee Wolfe				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-10-3752		17 INFORMANT ADDRESS Mr. Robert Bailey, Hagerstown, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <i>congestion failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Chronic Brain Syndrome</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/27</u> 19 <u>80</u> to <u>5/4</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5/4</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>Dr. J. H. Howerston</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/4/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SIDNEY NOVENSTEIN				22e. ADDRESS FUNKSTOWN MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE May 7, 1980		23c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Funkstown, Wash., Maryland			
24 FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR MAY 9 1980		25b. REGISTRAR'S SIGNATURE <i>Robert Bailey</i>			

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
8 0 1 3 / 8 1											
FOR STATE REGISTRAR Helen Louise Barger											
CERTIFICATE OF DEATH											
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH		MONTH DAY YEAR			
Helen Louise Barger						5 8 80		2b. HOUR			
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Female			Caucasian		7 21 04		75 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Washington County MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington County Hospital				Housewife					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland			Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route # 4 Box 607		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST			FIRST MIDDLE LAST								
Andrew R. Shank			Sarah Jane Socks								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS				
No			217-12-1096		Belle V. Kroboth		Route # 2 Box 18 Hagerstown, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>cardiac congestive heart failure</u>										1 week	
410 - DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u>										1 week	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerotic heart disease</u>										years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
<u>Generalized atherosclerosis</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
			P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>78</u> to <u>5/18/80</u> 19 <u>80</u> , that (I) (we) <u>did</u> <u>not</u> saw the deceased alive on <u>5/18/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <u>did</u> <u>not</u> view the body after death.											
22b. SIGNATURE			DEGREE			22c. DATE SIGNED					
Edson B. Moody						5/19/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
Edson B. Moody M.D.			St. James Road, Hagerstown, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			5-12-80		Cedar Lawn Memorial Pk. Hagerstown, Washington, Md.						
24 FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
A.K. Coffman Funeral Home, Inc., Hagerstown, Md.						MAY 14 1980		Edson B. Moody			

John L. ...

Washington ...

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 3 / 8 2	
FOR 1 - STATE REGISTRAR										CERTIFICATE OF DEATH	
1 DECEASED NAME (TYPE OR PRINT)										2a DATE OF DEATH	
FIRST MIDDLE LAST										MONTH DAY YEAR	
Hazel Levina BARNHART										May 17, 1980	
3 SEX										4 RACE	
Female										White	
5 DATE OF BIRTH										6 AGE (IN YEARS LAST BIRTHDAY)	
MONTH DAY YEAR										YRS MONTHS DAYS HOURS MIN	
Sept. 12, 1908										71	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b CITIZEN OF WHAT COUNTRY?	
Pennsylvania										U.S.A.	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9 BALTIMORE CITY OR COUNTY OF DEATH	
										Washington MD.	
10 CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Hagerstown										114 Windsor Drive	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b KIND OF BUSINESS OR INDUSTRY	
Sewer										Knitting Co.	
13a STATE										13b CITY OR TOWN	
Md.										Hagerstown	
14 FATHER'S NAME										15 MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST										FIRST MIDDLE LAST	
George W. Boward										Molly - Cunningham	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b SOCIAL SECURITY NO	
no										173-03-2569	
17 INFORMANT										ADDRESS	
Mr. Billie D. Barnhart, Hagerstown, Md.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of uterus - endometrial</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1820										8 years	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension.</u>											
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY?										20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
										P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d INJURY OCCURRED										21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from <u>Aug 6</u> , 19 <u>79</u> , to <u>May 17</u> , 19 <u>80</u> , that (2) (myself) saw the deceased alive on <u>April 18</u> , 19 <u>80</u> , and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (If two doctors did not view the body after death.)										22c DATE SIGNED	
22b SIGNATURE										22d ADDRESS	
DEGREE											
Attending Physician <input type="checkbox"/> Medical Director <input checked="" type="checkbox"/> Staff Physician <input type="checkbox"/>											
22d PHYSICIAN'S NAME (TYPE OR PRINT)										22e ADDRESS	
Richard E. Smith, M.D.											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)										23b DATE	
Burial										May 21, 1980	
23c NAME OF CEMETERY OR CREMATORY										23d LOCATION CITY OR TOWN COUNTY STATE	
Cemetery										Leitersburg, Md.	
24 FUNERAL DIRECTOR NAME										25a DATE REC'D. BY REGISTRAR	
Dennis L. Davis										MAY 23 1980	
Davis Funeral Home, Smithsburg, Md.										25b SIGNATURE	

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MAY 1960

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 3 7 8 3			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
Martha Jane BARR				May 26, 1980			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
female		white		MONTH DAY YEAR		YRS	
June 17, 1902		77		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?	
Maryland		USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Washington		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Hagerstown		431 Liberty Street		housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE				13b. COUNTY			
Maryland				Washington			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
Samuel Gail Kinsey				Susan Winters			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO			
No				217-42-7699			
17. INFORMANT				ADDRESS			
Jack Barr, Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liver</u> <u>1552</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Diabetes</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/15/80</u> , 19____, to <u>5/26/80</u> , 19____, that (I) (we) lost saw the deceased alive on <u>5/15/80</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>R. H. Campbell MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robt V. H Campbell</u>				22e. ADDRESS <u>Hagerstown Md</u>			
23a. BURIAL, CREMATION, REMOVAL <u>burial</u>		23b. DATE <u>May 28, 1980</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beaver Creek Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Hagerstown, Wash., Maryland</u>	
24. FUNERAL DIRECTOR NAME <u>MINNICH FUNERAL HOME</u> ADDRESS <u>415 E. Wilson Blvd., Hagerstown, Md. 21740</u>				25a. DATE REC'D. BY REGISTRAR <u>JUN 2 1980</u>		25b. REGISTRAR'S SIGNATURE <u>Barbara McHenry</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after burial. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	1	3	7	8	4			
1- FOR STATE REGISTRAR										REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)			FIRST Elmer			MIDDLE Clinton			LAST BLACK			2a DATE OF DEATH MONTH DAY YEAR May 5, 1980			2b HOUR 12:22 P.M.				
3 SEX male			4 RACE white			5 DATE OF BIRTH MONTH DAY YEAR January 31, 1906			6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.										
10 CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) turntable operator			12b KIND OF BUSINESS OR INDUSTRY railroad										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a STATE Maryland			13b CITY OR TOWN Washington			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d STREET ADDRESS 712 Point Salem Road							
14 FATHER'S NAME FIRST MIDDLE LAST William Black						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Myers													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 217-18-8341			17 INFORMANT Mrs. Gertrude Black, Hagerstown, Md.						ADDRESS							
18 CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, Hypertension</u> (c) <u>Coronary Artery Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 yrs</u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																			
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE 4128 2117 69 515 80													
22a I certify that (I) (this hospital) attended the deceased from <u>4/28</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b SIGNATURE <u>Donald E Martin MD</u>										DEGREE MD			22c DATE SIGNED 5/6/80						
22d PHYSICIAN'S NAME (TYPE OR PRINT) DONALD E MARTIN MD										22e ADDRESS 353 S Cleveland Ave Hagerstown									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) black			23b DATE May 8, 1980			23c NAME OF CEMETERY OR CREMATORY Broadfording Cemetery			23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland										
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME										25a DATE REC'D. BY REGISTRAR MAY 9 1980			25b REGISTRAR'S SIGNATURE <u>[Signature]</u>						
415 E. Wilson Blvd., Hagerstown, Maryland																			

BP



9/27

Plumage of the female  
to the male of the  
same species.

For the male of the  
same species.  
[unclear]  
[unclear]  
[unclear]



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 3 / 8 5			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Bruce Benton BLUBAUGH				May 4, 1980				2:35P M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS	
Male		White		Sept. 18, 1894		85 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Franklin Co. Pa.		U. S. A.				Washington MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Colton Villa Nursing Home						Labor		Construction	
13a. STATE				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
Maryland				Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		103 E. Antietam St.			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
Edward Benton Blubaugh				Mary Elizabeth Mentzer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
No				217-03-4781		Mrs. Agnes Flook, Sharpsburg, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHF										1 day	
4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD										m	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) Gen Arterio-sclerosis										m	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CVA, Emphysema											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 1, 1976, to 5.4. 1980, that (I) (we) lost saw the deceased alive on 4.3. 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Vasant Datta				MD				5.6.80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
VASANT DATTA, MD				1600 OAK HILL AVE, HAGERSTOWN, MD 21748							
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				5-7-80		Boonsboro Cemetery		Boonsboro, Wash. Co., Md.			
24 FUNERAL DIRECTOR NAME						24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE	
John H. Bast, Jr.						Boonsboro, Md. 21713		MAY 8 1980		[Signature]	

John A. Bane, Jr., Booneville, Mo. 64601

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Booneville, Mo. 64601

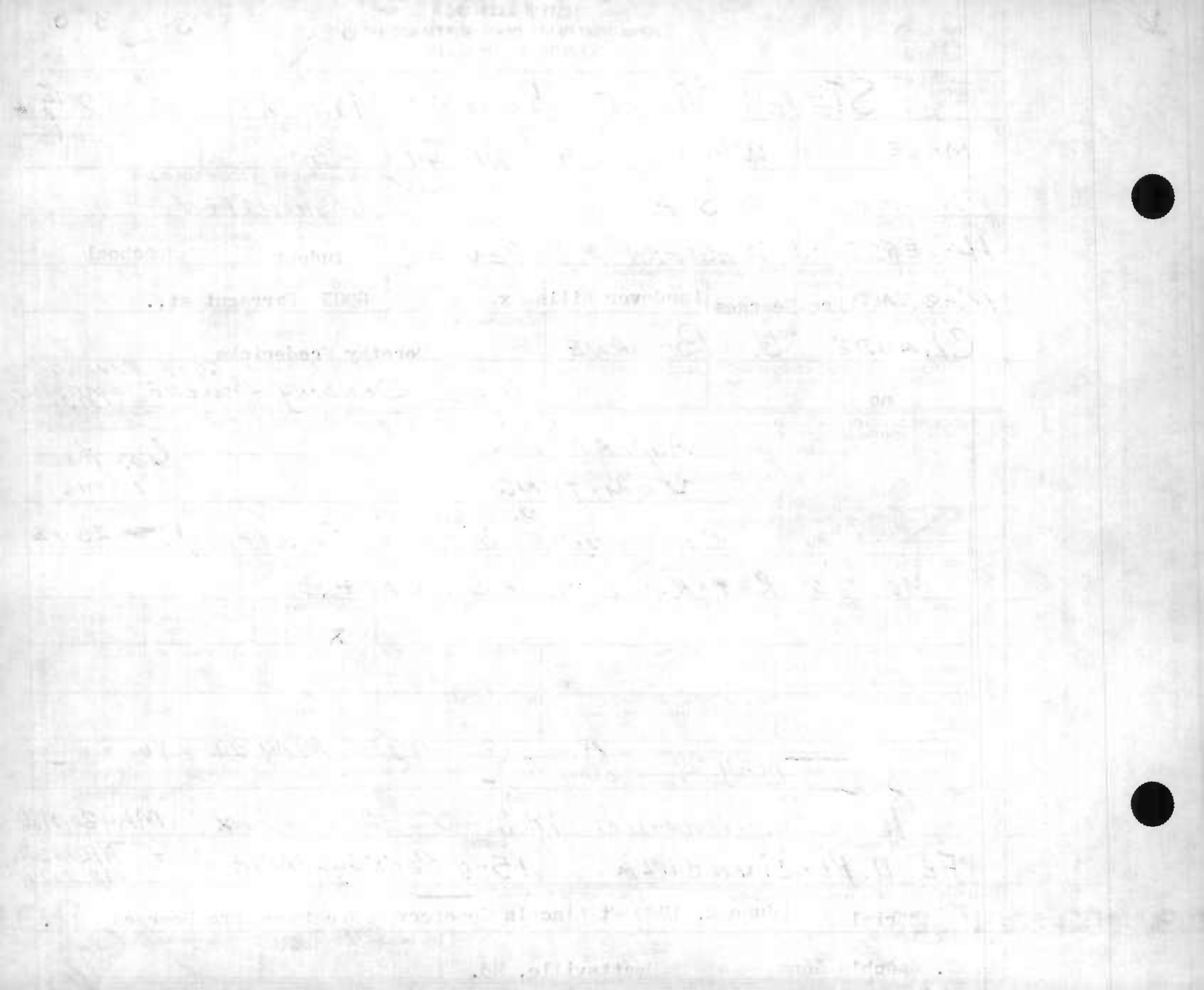
Booneville, Mo. 64601

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 3 7 8 6	
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH							REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
STEVEN VINCENT BOURNE			May 29, 1980			8 15			P M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR		7 UNDER 2 HRS	
MALE		WHITE		9 29 49		30 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Washington D C		U.S.A				WASHINGTON					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN		WESTERN M.D. CENTER				Student		school			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. CITY OR TOWN			13b. STREET ADDRESS					
13a. STATE			13b. COUNTY			13c. INSIDE CITY LIMITS?			13d. STREET ADDRESS		
MARYLAND			Pro Georges			Landover Hill			6903 Farragut st.,		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
CLAUDE C. BOURNE			Dorothy Fredericks								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
no						6903 FARRAGUT ST. MRS. DOROTHY BOURNE HYATTSVILLE MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) ASPIRATION										less than 1 hour	
3459 DUE TO, OR AS A CONSEQUENCE OF											
VOMITING											
DUE TO, OR AS A CONSEQUENCE OF											
PRESUMABLY CONVULSIVE SEIZURE (EPILEPSY)										2548	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MENTAL RETARDATION & BLINDNESS											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK						STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from April 13, 1972, to May 29, 1980, that (I) (we) lost saw the deceased alive on MAY 29, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED		
Fe U. Porciuncula M.D.									MAY 30, 1980		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
FE U. PORCIUNCULA			1500 PENNSYLVANIA AVE. HAGERSTOWN MD 21224								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			June 2, 1980			Ft Lincoln Cemetery			Brentwood Pro Georges Md.		
24. FUNERAL DIRECTOR			NAME			ADDRESS			25a. DATE RECEIVED BY REGISTRAR 1980		
F. Gasch's Sons P A			Hyattsville, Md.						25b. REGISTRAR'S SIGNATURE		



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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Laura Virginia BROWN			2a. DATE OF DEATH MONTH DAY YEAR May 8, 1980		2b. HOUR 9:20 <sup>A</sup> M	
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 5, 1898	6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10 CITY OR TOWN OF DEATH Boonsboro	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reeders Memorial Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 1503 Pentridge Rd.		
14 FATHER'S NAME FIRST MIDDLE LAST Charles T. Blacksten		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Virginia Poole				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-10-0979		17. INFORMANT ADDRESS Ave. Russell C. Brown 4005 Chestmont		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4029 DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sev. years</u> <u>sev. years</u>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (b) (this hospital) attended the deceased from <u>May 17</u> , 19 <u>78</u> , to <u>May 8</u> , 19 <u>80</u> , that (b) (we) last saw the deceased alive on <u>May 6</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did not) view the body after death.						
22b. SIGNATURE <u>E. Bieber</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-8-80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD BIEBER, M.D.		22e. ADDRESS P.O. Box 246, Keedysville, Md., 21756				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-10-80	23c. NAME OF CEMETERY OR CREMATORY Uniontown Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE Carroll, Maryland	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins Sons Co.		ADDRESS 4905 York Rd. Balto., Md. 21212		25a. DATE REC'D. BY REGISTRAR MAY 9 1980		25b. REGISTRAR'S SIGNATURE <u>Richard Halzandy</u>

BP

DHMM-16 25M  
(VRA 15, 4) 1/79

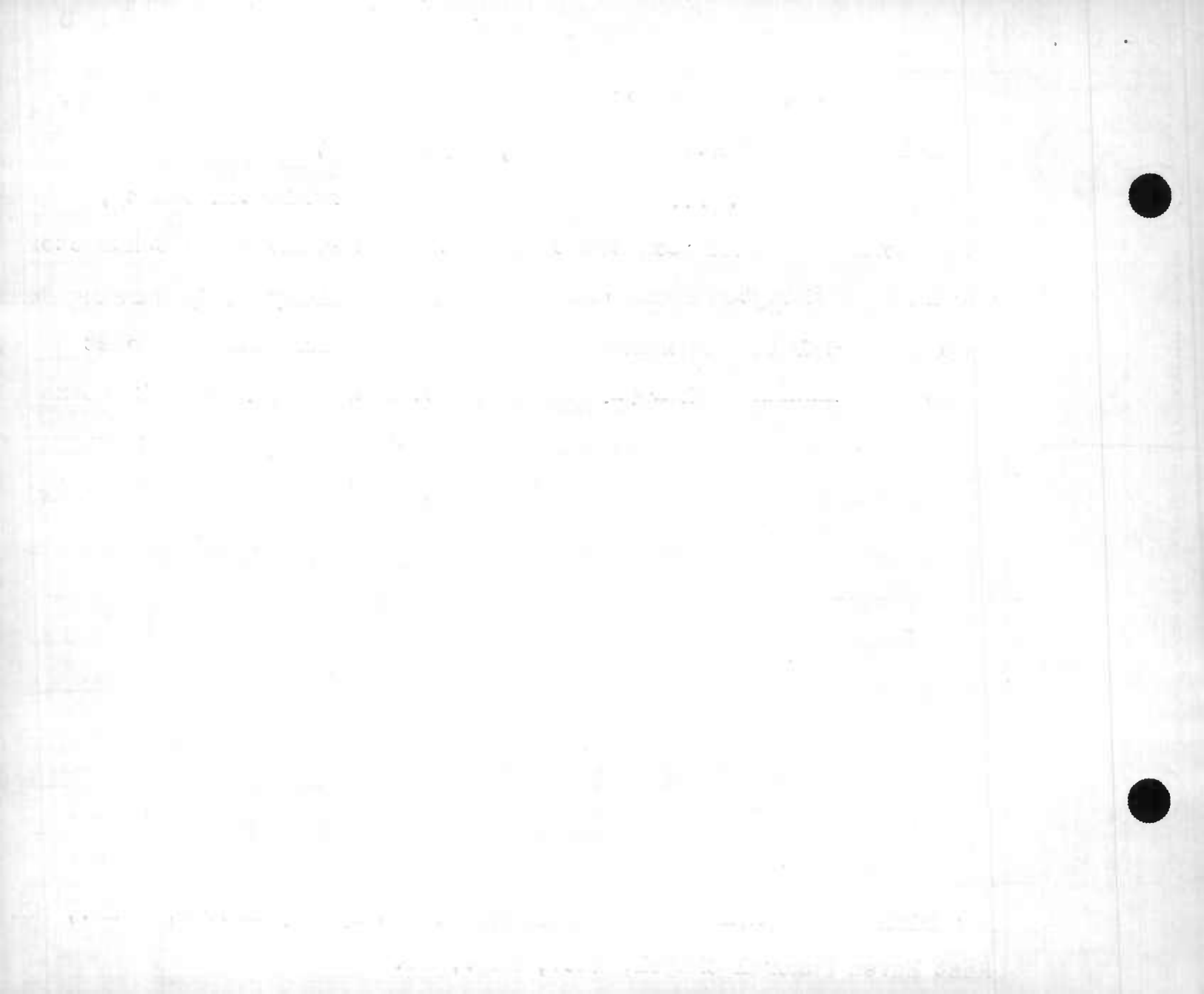


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 3 / 8 8					
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH						REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) James M onroe BUCHANAN				2a DATE OF DEATH 5-5-80				2b HOUR 5 P. M.							
3 SEX Male		4 RACE White		5 DATE OF BIRTH May 30, 1892		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7a IF UNDER 1 YEAR MONTHS OAYS		7b IF UNDER 24 HRS HOURS MIN					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.									
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b KIND OF BUSINESS OR INDUSTRY Contractor							
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Maryland				13c CITY OR TOWN Boonsboro		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Fahrney Keedy Nursing Home							
14 FATHER'S NAME 14a FIRST John				14b MIDDLE Calvin		14c LAST Buchanan		15 MOTHER'S MAIDEN NAME 15a FIRST Mary				15b MIDDLE Elizabeth		15c LAST Horst	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17 INFORMANT David C. Buchanan, 3 Woodbine Lane									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pneumonia hypoxia &amp; CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ABCD &amp; Generalized Arteriosclerosis</u> 7-10 days										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7-10 days</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>CVA</u>															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>March 3</u> , 19 <u>79</u> , to <u>5-5</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>5-5</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b SIGNATURE <u>Vasant Datta</u> MD				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 5-5-80					
22d PHYSICIAN'S NAME (TYPE OR PRINT) VASANT DATTA, M.D.				22e ADDRESS 1600 OAK HILL AVE, HAGERSTOWN, MD 21740											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 5-7-80		23c NAME OF CEMETERY OR CREMATORY Broadfording Cemetery		23d LOCATION CITY OR TOWN Hagerstown		COUNTY STATE Wash., Md.					
24 FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag., Md.				ADDRESS				25a DATE RECEIVED BY REGISTRAR MAY 12 1980		25b REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>					





DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13789	
1. DECEASED NAME (TYPE OR PRINT) <b>IRWIN JAMES CAMERON</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>APR. 21 1980</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 5, 1912</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>67</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7b. HOUR <b>8:00</b> A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VERMONT</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7c. DATE PRONOUNCED DEAD <b>APRIL 21 1980</b> A M	
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON COUNTY HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FARMER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	
13a. STATE <b>VERMONT</b>				13b. COUNTY <b>ADDISON</b>		13c. CITY OR TOWN <b>BRANDON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>ROUTE #2</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter James Cameron</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JESSIE ELLEN NEWTON</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>009-05-5024</b>		17. INFORMANT ADDRESS <b>GLADYS M. CAMERON, RT.#2, BRANDON, VT.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>#427 - CARDIAC ARREST DUE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>#429 - ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HR.</b> <b>YEARS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Edward W. Ditto</i>						TITLE (SPECIFY) <b>DEPUTY</b>			DATE SIGNED <b>MAY 1, 1980</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>						ADDRESS <b>HAGERSTOWN, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>4-24-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORRESTDALE CEMETERY</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>FORRESTDALE VERMONT</b>	
24. FUNERAL DIRECTOR NAME <b>GERALD N. MINNICH</b>						ADDRESS <b>HAGERSTOWN, MARYLAND</b>			25a. DIED BY REC'D. BY REGISTRAR <b>MAY 8 1980</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	1	3	7	9	0	
1. FOR STATE REGISTRAR										REG. NO.							
1 DECEASED NAME (TYPE OR PRINT) Clara Viola Carbaugh										2a. DATE OF DEATH May 6, 1980				2b. HOUR 9:50 P.M.			
3 SEX Female			4 RACE White			5 DATE OF BIRTH March 29, 1886			6 AGE (IN YEARS LAST BIRTHDAY) 94 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.								
10 CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Avalon Manor Nursing Home							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland										13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 417 Wyoming Avenue	
14 FATHER'S NAME FIRST MIDDLE LAST Samuel Beckley										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary I. Hershey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No										16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-7983		17 INFORMANT I. Scott Carbaugh				ADDRESS Route # 2 Box 317-A Hagerstown, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Indefinite							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebral vascular disease																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (the doctor) attended the deceased from May 6, 1980, to May 6, 1980, that (I) (was) last saw the deceased alive on May 6, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE B. B. Kneisley, M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (TYPE OR PRINT) B. B. Kneisley, M.D.										22d. ADDRESS 148 West Washington Street Hagerstown, Md. 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-9-80			23c. NAME OF CEMETERY OR CREMATORY Broadfording Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md.								
24 FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md.										25a. DATE OF DEATH 25b. PHOTOGRAPH SIGNATURE							

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillian Mae CARROLL						2a. DATE OF DEATH MONTH DAY YEAR May 8, 1980		2b. HOUR 4:15 PM	
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR January 30, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garlock Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY shoe company			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Charles F. Ripple						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula L. Smith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS Gladys Isanogle, Hagerstown, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>10/14</u> 19 <u>77</u> to <u>5/8</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5/8</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Admiral Novostein</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>5/9/80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>210 WY NOVOSTEIN FUNKSTOWN MD</u>				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE May 12, 1980		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland					
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR MAY 14 1980		25b. REGISTRAR'S SIGNATURE <u>Henry McBratney</u>					

RECEIVED  
MAY 1 1961  
U.S. AIR FORCE

OFFICE OF THE  
JOINT CHIEFS OF STAFF

MEMORANDUM FOR THE RECORD

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

MAY 1 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

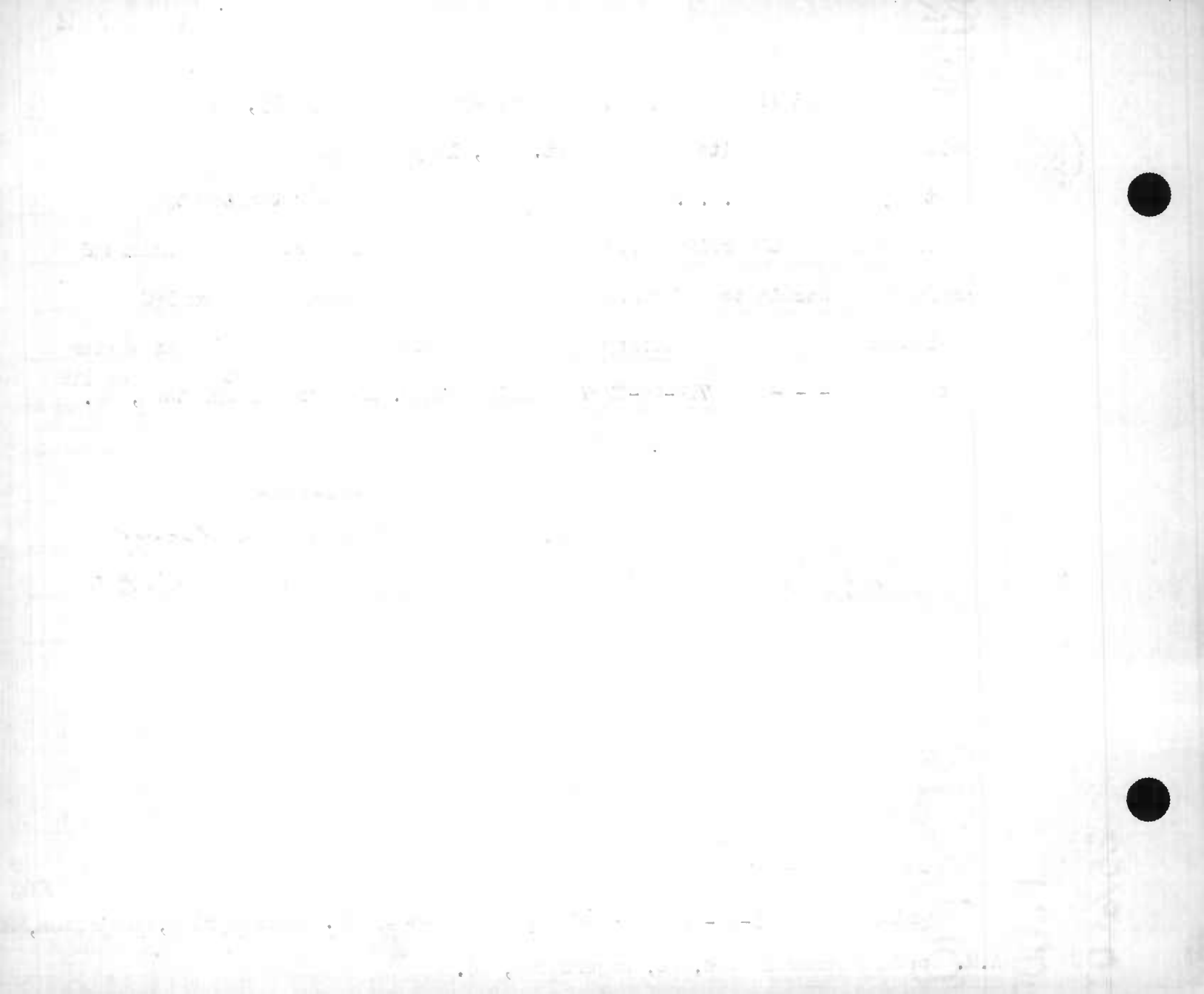
IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 18a G544 6/6/80 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William (NMN) Caskey</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 13, 1980</b>		2b. HOUR M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 22, 1883</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b> YRS.	7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Clearview Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Inspector</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>	13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>Route # 8 Box 198</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Caskey</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Le Master</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>702-09-2797</b>	17. INFORMANT ADDRESS <b>Elizabeth C. Clopper Route # 8 Box 198 Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion</b> <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Embolism</b> (c) <b>Arteriosclerotic Cardiovascular Disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Prostatic Adenoma, uremia, heart infection, Scurvy</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that (a) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>Natural</b>					
22b. SIGNATURE <b>J. D. Wilson / M. Sarampote</b>			22c. DATE SIGNED <b>5-16-80</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROLANDO V. SARAMPOTE MD</b>			22e. ADDRESS <b>879 COMMONWEALTH AVE HAGERSTOWN</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>5-16-80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blairs Valley Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clear Spring, Washington, Md</b>	
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>MAY 19 1980</b>		
25b. REGISTRAR'S SIGNATURE <b>Robert M. [Signature]</b>					



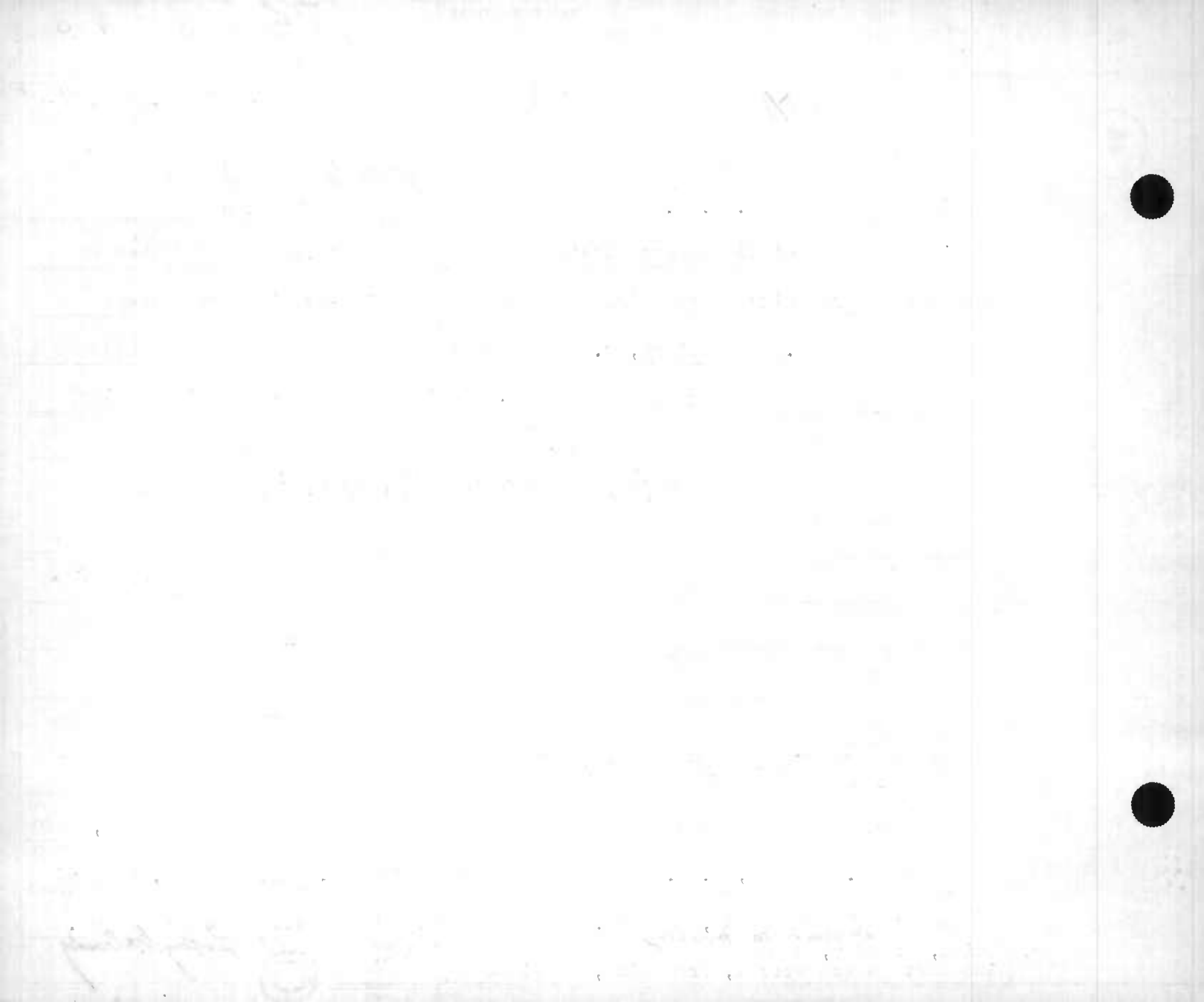


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 5 1 3 7 9 3 CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>DAISY L. CLARK</b>					2a. DATE OF DEATH MONTH <b>5</b> DAY <b>15</b> YEAR <b>80</b>					2b. HOUR <b>6:45</b> MIN. <b>57</b>
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>March</b> DAY <b>17</b> YEAR <b>1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.				
10. CITY OR TOWN OF DEATH <b>Williamsport</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Williamsport Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7 East Fifteenth Street</b>		
14. FATHER'S NAME FIRST <b>Lewis</b> MIDDLE <b>F.</b> LAST <b>Clark, Sr.</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Nina</b> MIDDLE <b>Belle</b> LAST <b>Snoots</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214 54 0074</b>		17. INFORMANT ADDRESS <b>Mrs. Tillie Engle, ( Same as item # 13e)</b>						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Arrhythmia</b> <b>496 -</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Chronic Obstructive Pulmonary Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b></b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <b>4-3</b> , 19 <b>80</b> , to <b>5-1</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>5-15</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>John R. Melnick</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>May 15, 1980</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John R. Melnick, M. D.</b>				22e. ADDRESS <b>16220 Frederick Rd. Gaithersburg, Maryland 20760</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 19, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Frederick</b> COUNTY <b>Frederick</b> STATE <b>Md.</b>				
24. FUNERAL DIRECTOR <b>Smith, Faeley, Keeney &amp; Bassford Funeral Home</b>				25a. DATE RECEIVED BY REGISTRAR <b>MAY 21 1980</b>		25b. SIGNATURE <b>John R. Melnick</b>				
106 East Church Street, Frederick, Maryland										



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST DORIS			MIDDLE L.			LAST COE			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH MAY			DAY 10			YEAR 1980			7b. HOUR 3:28 PM									
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR MAY 27 1913			6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS.			7c. DATE PRONOUNCED DEAD			MONTH MAY			DAY 10			YEAR 1980			7d. HOUR 3:30 PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH WASH												MD.									
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY															
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																																	
13a. STATE West Virginia				13b. COUNTY Ohio				13c. CITY OR TOWN Wheeling				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 24 Birch Avenue																	
14. FATHER'S NAME FIRST MIDDLE LAST M. M. Spence						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Winefred Wyont																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO. 232-62-9135						17. INFORMANT ADDRESS Mr. Robert Coe, Whelling, West Virginia																					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>E814 Robustian struck by motor vehicle</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HRS															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																																	
19a. DATE OF OPERATION MAY 10 80						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Head injury & abd. injuries												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:33 PM MAY 10 80						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Hit by car crossing Rt 40																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) U.S. 40						21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8 mi W. of Hancock WASH MD																					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																																	
ACTUAL SIGNATURE H. N. Weeks						TITLE (SPECIFY) Dep						MEDICAL EXAMINER						DATE SIGNED MAY 10, 1980															
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS 580 Norton Ave Hagerstown WASH. MD																											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial						23b. DATE May 14, 1980						23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery						23d. LOCATION CITY OR TOWN COUNTY STATE Wheeling, W. Va.															
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME												25a. DATE REC'D. BY REGISTRAR MAY 16 1980												25b. REGISTRAR'S SIGNATURE Ruthy Beland									
415 E. Wilson Blvd., Hagerstown, Maryland 21740																																	

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

2. The second part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the elements. It is shown that the theory of the structure of the atom can be used to explain the periodicity of the elements, and that it can be used to predict the properties of the elements.

3. The third part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the compounds. It is shown that the theory of the structure of the atom can be used to explain the properties of the compounds, and that it can be used to predict the properties of the compounds.

4. The fourth part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the molecules. It is shown that the theory of the structure of the atom can be used to explain the properties of the molecules, and that it can be used to predict the properties of the molecules.

5. The fifth part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the solids. It is shown that the theory of the structure of the atom can be used to explain the properties of the solids, and that it can be used to predict the properties of the solids.

6. The sixth part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the liquids. It is shown that the theory of the structure of the atom can be used to explain the properties of the liquids, and that it can be used to predict the properties of the liquids.

7. The seventh part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the gases. It is shown that the theory of the structure of the atom can be used to explain the properties of the gases, and that it can be used to predict the properties of the gases.

8. The eighth part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the plasmas. It is shown that the theory of the structure of the atom can be used to explain the properties of the plasmas, and that it can be used to predict the properties of the plasmas.

9. The ninth part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the stars. It is shown that the theory of the structure of the atom can be used to explain the properties of the stars, and that it can be used to predict the properties of the stars.

10. The tenth part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the universe. It is shown that the theory of the structure of the atom can be used to explain the properties of the universe, and that it can be used to predict the properties of the universe.

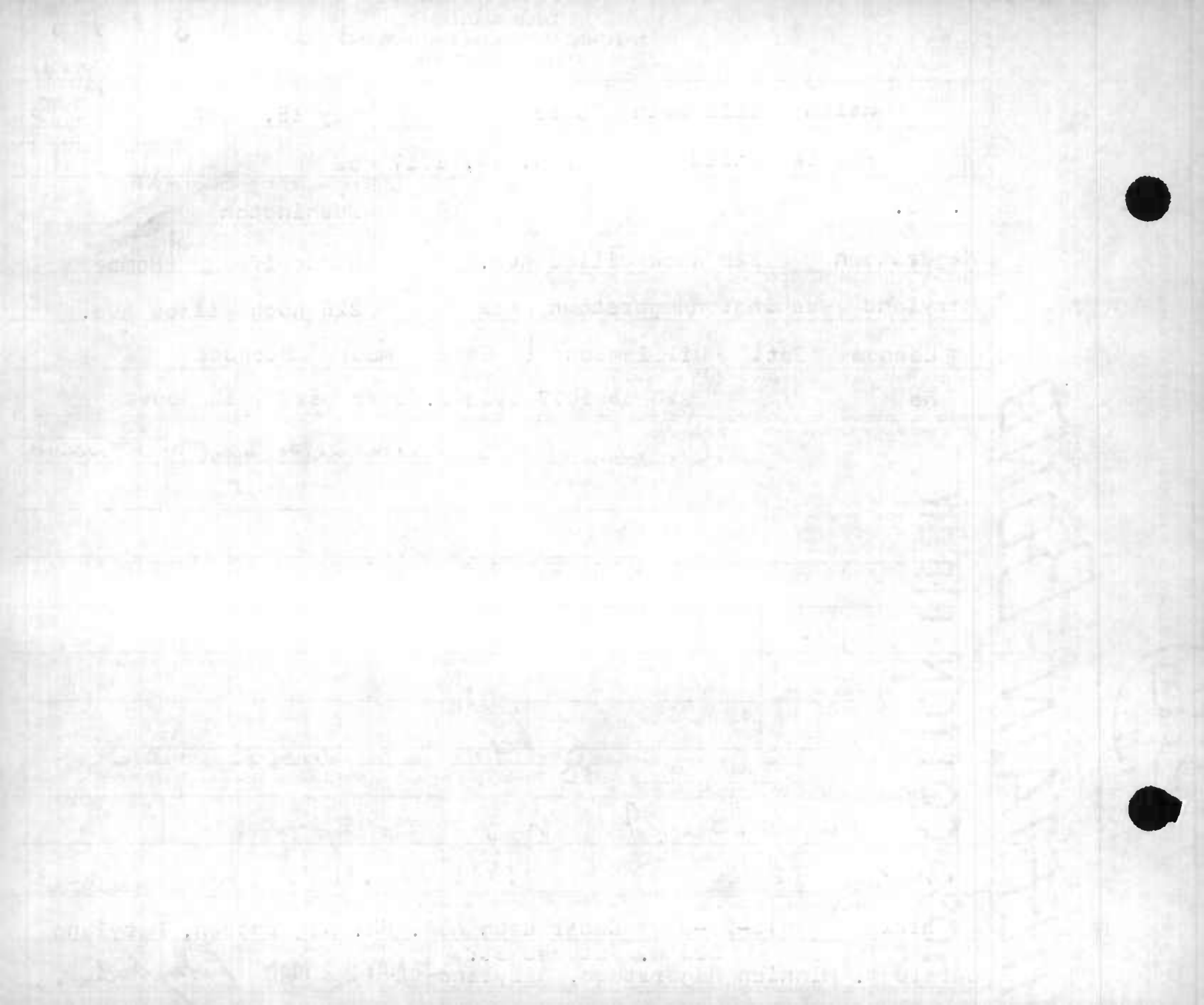
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 3 7 9 5	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Elizabeth Darr			2a. DATE OF DEATH MONTH DAY YEAR May 15, 1980		2b. HOUR 3:00 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 14, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 228 Rock Willow Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Maryland			13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Leedom Jett Williamson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Mae Stroupe		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220 34 1077	17. INFORMANT ADDRESS Lyle O. Darr see # 13 above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon, liver metastases</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>Oct 79</u> , 19 <u>80</u> , to <u>May 15</u> , 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>May 9</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Leedom A. Darr A.		DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederic H. Kress D.		22e. ADDRESS 1825 Howell Rd, Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-20-80	23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Maryland	
24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland		305 N. Potomac St.		25a. DATE REC'D. BY REGISTRAR MAY 22 1980	25b. REGISTRAR'S SIGNATURE Ruthy McCreedy



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 3 7 9 6 CERTIFICATE OF DEATH									
FOR 1 - STATE REGISTRAR				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Francis Moe Davis</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>5 27 80</b>				2b. HOUR <b>355 P M</b>	
3 SEX <b>female</b>		4 RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>December 30, 1940</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>39</b> YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY <b>supermarket</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Route 2, Box 292</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Gilbert L. Cole</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen V. Virts</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>216-38-2494</b>		17. INFORMANT ADDRESS <b>Roy E. Davis, Hagerstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of breast with extensive</b> <b>1749</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>liver, pleural metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 months</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>5/27/80</b>		CITY OR TOWN <b>19</b>		COUNTY <b>5/27/80</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>5/27/80</b> 19 to <b>5/27/80</b> , that (I) (we) last saw the deceased alive on <b>5/27/80</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Frederic H. Koss III</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/27/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frederic H. Koss III</b>				22e. ADDRESS <b>1825 Howell Rd Hagerstown Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>May 30, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Park</b>		23d. LOCATION CITY OR TOWN <b>Hagerstown, Wash., Maryland</b>		STATE	
24. FUNERAL DIRECTOR NAME <b>Minichs 415 E. Wilson Blvd</b>				ADDRESS <b>Hagerstown, Wash., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 2, 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>	

BP \_\_\_\_\_

DHMM-16 25M  
(VRA 15, 4) 1/79





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 3 7 9 7  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Blanche Irene DEAN			2a. DATE OF DEATH MONTH DAY YEAR May 7, 1980			2b. HOUR M					
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR March 10, 1892		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Doctor		12b KIND OF BUSINESS OR INDUSTRY Chiropractor			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE Md.		13b COUNTY Wash.		13c CITY OR TOWN Smithsburg		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Rt. 3 Box 55			
14 FATHER'S NAME FIRST MIDDLE LAST Thomas S. Holmes						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Campbell					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212-38-8901		17 INFORMANT ADDRESS Mr. Alan B. Metzler Smithsburg, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Septicemia</i> <i>2500</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>urinary tract infection</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <i>Diabetes mellitus</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Dehydration</i> <i>Arteriosclerotic Cardiovascular disease</i>											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>July 13, 1976</i> , to <i>May 7, 1980</i> , that (I) (we) last saw the deceased alive on <i>May 7, 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>R. V. Sarampote</i>						DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>5/9/80</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. V. SARAMPOTE</i>						22e ADDRESS <i>879 Commonwealth Ave. 21760 Hager MD</i>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE May 10, 1980		23c NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery				23d LOCATION CITY OR TOWN COUNTY STATE Smithsburg Wash. Md.	
24 FUNERAL DIRECTOR NAME <i>Dennis Davis</i>						25a DATE REC'D. BY REGISTRAR MAY 14 1980					
25b REGISTRAR'S SIGNATURE <i>Dennis Davis</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO.			7 0 1 3 7 9 8				
1 DECEASED NAME (TYPE OR PRINT) George Arthur Drake, Sr.			2a DATE OF DEATH MONTH DAY YEAR May 29, 1980			2b HOUR 11:00P <sub>M</sub>				
3 SEX Male		4 RACE White		5 DATE OF BIRTH Sept. 21, 1929		6 AGE (IN YEARS LAST BIRTHDAY) 50		7 UNDER 1 YEAR MONTHS DAYS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mt. Briar, Md.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10 CITY OR TOWN OF DEATH Keedysville		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO SUCH FACILITY, GIVE STREET ADDRESS) Rfd. 1 Box 33				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Line Forman		12b KIND OF BUSINESS OR INDUSTRY Power Co.		
13a STATE Maryland			13b COUNTY Washington		13c CITY OR TOWN Keedysville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Rfd. 1 Box 33	
14 FATHER'S NAME William Lewis Drake			15 MOTHER'S MAIDEN NAME Atha G. Norris							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO OR UNKNOWN Yes Korean Conflict			16b SOCIAL SECURITY NO. 218-24-1367		17 INFORMANT ADDRESS Mrs. Patricia A. Drake, Rfd. 1 Box 33 Keedysville, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno carcinoma pancreas</u> 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-8 Mos										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Diabetes Mellitus</u>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) <u>this hospital</u> attended the deceased from <u>Feb 22</u> , 19 <u>80</u> to <u>May 29</u> , 19 <u>80</u> , that (I) <u>was</u> last saw the deceased alive on <u>Apr 28</u> , 19 <u>80</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>was</u> (did) (did not) view the body after death.										
22b SIGNATURE <u>Schaul W. Dittus MD</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED May 30, 1980		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Edward W. Dittus MD			22e ADDRESS 217 W. Washington St. Hagerstown, Md 21740							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 6-1-80		23c NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Keedysville, Wash. Co., Md.			
24 FUNERAL DIRECTOR John H. Bast, Jr.			ADDRESS Boonsboro, Md. 21713			25a DATE RECD. BY REGISTRAR JUN 3 1980		25b RECORDING SIGNATURE <u>Patricia A. Drake</u>		

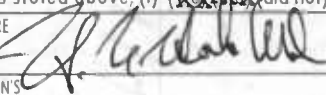
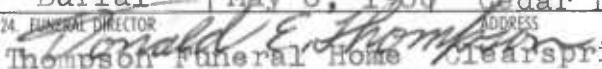
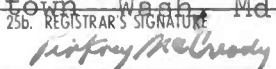


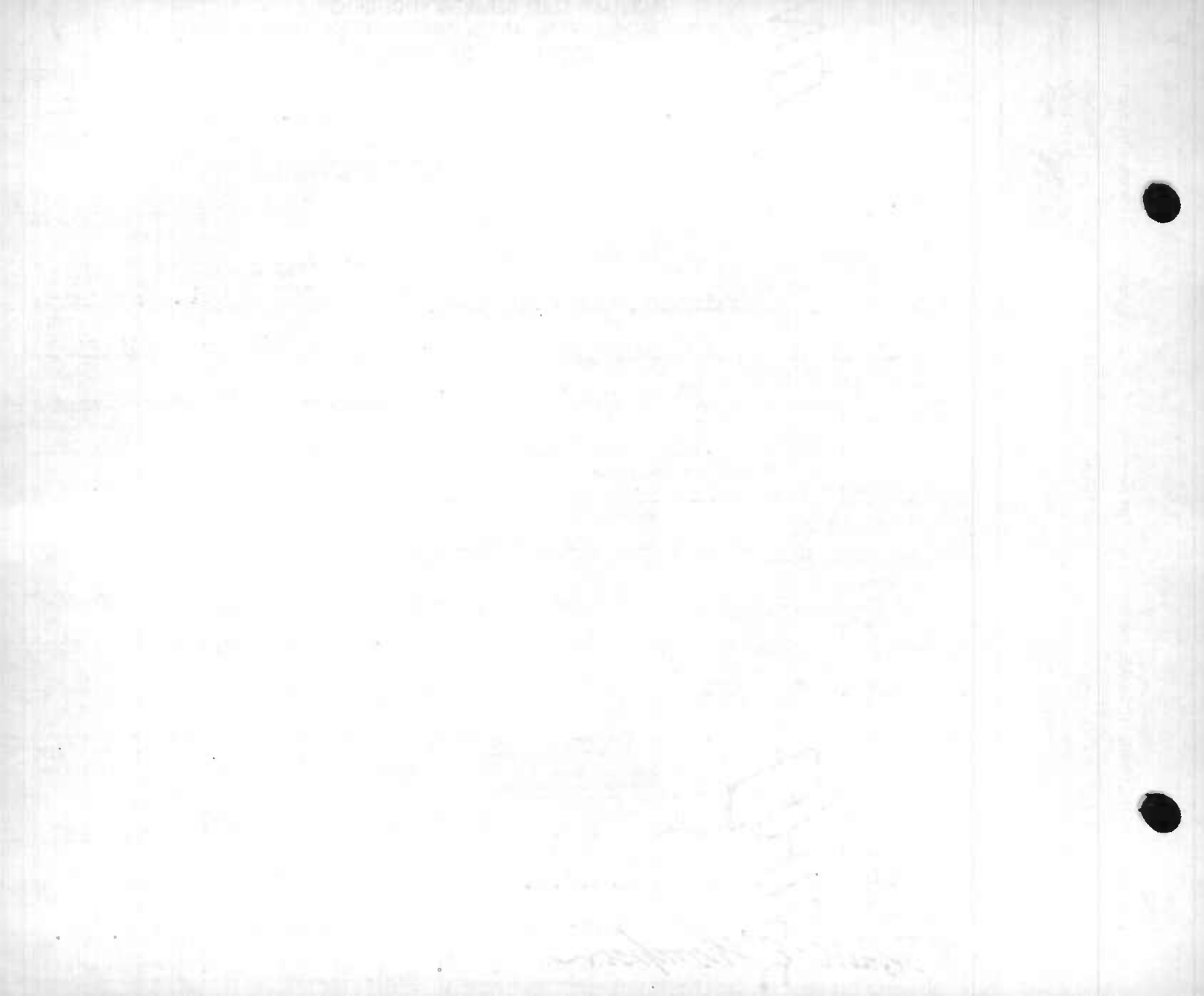
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VRA 15 (4)  
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21203 7 9 9  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Elizabeth Teresa Dyer</b>			2a. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>1980</b>			2b. HOUR <b>12 30 PM</b>		
3. SEX <b>Female</b>	4. RACE <b>White</b>		5. DATE OF BIRTH <b>Jan. 13, 1920</b>		6. AGE (In years last birthday) <b>60</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>		MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington County</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>301 Nottingham Road</b>
14. FATHER'S NAME First <b>William</b> Middle <b>Winfield</b> Last <b>Winfield</b>			15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Himmer</b> Last <b>Winfield</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>217-10-1206</b>		17. INFORMANT Address <b>Joseph Dyer 301 Nottingham Rd.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>436- (b) Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) <del>was not</del> attended the deceased from <b>Oct</b> , 19 <b>65</b> , to <b>May 5</b> , 19 <b>80</b> , that (I) <del>was</del> saw the deceased alive on <b>May 5</b> , 19 <b>80</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>will not</del> (did not) view the body after death.								
22b. SIGNATURE 		M.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>May 6, 1980</b>		
22d. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.P.A.</b>		22e. ADDRESS <b>580 Northern Avenue Hagers. MD</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 8, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash. Md.</b>		
24. FUNERAL DIRECTOR  <b>Thompson Funeral Home</b>		25a. REC'D BY REGISTRAR <b>MAY 13 1980</b>		25b. REGISTRAR'S SIGNATURE 				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

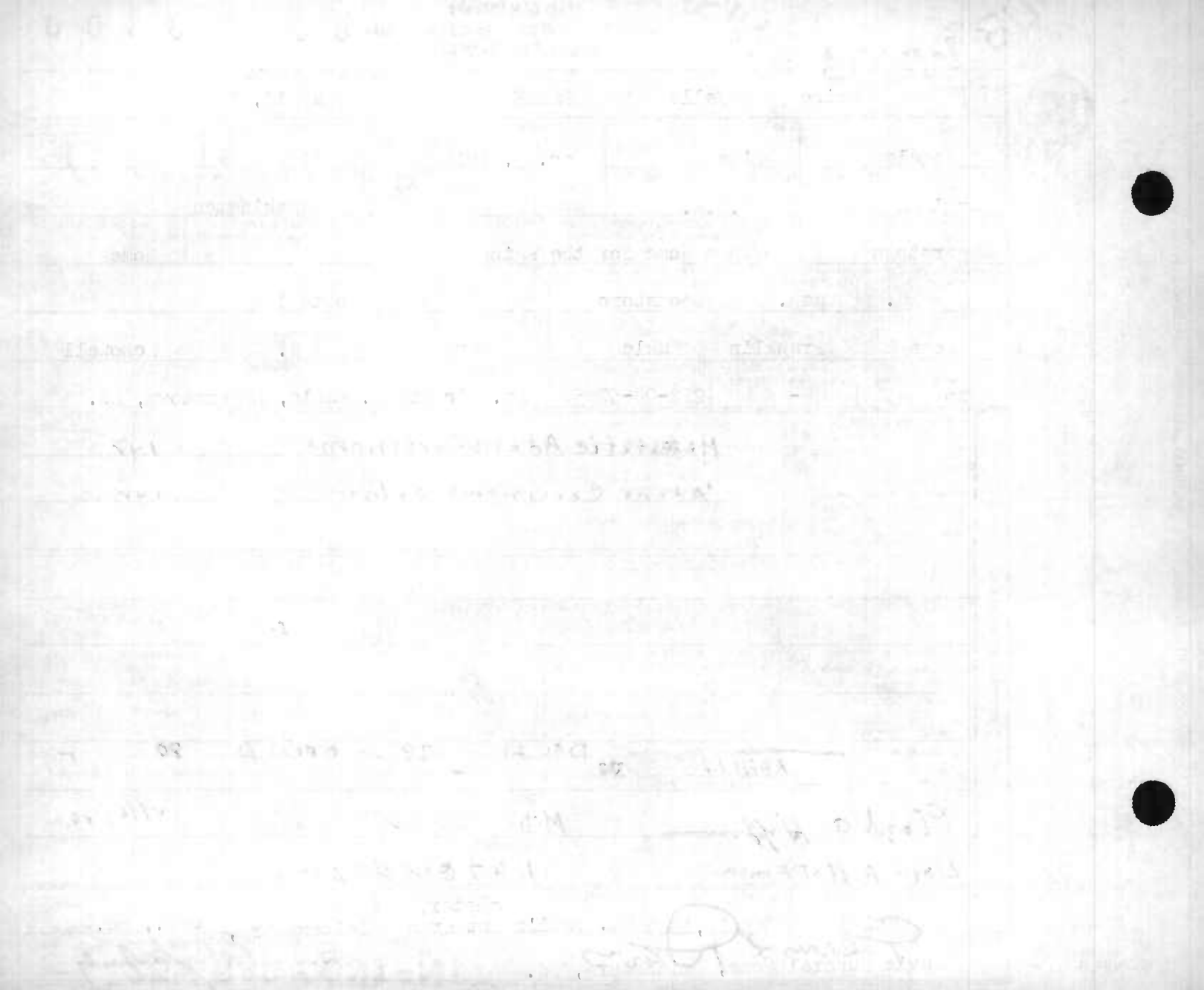
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 0 1 3 8 0 0			
1 - FOR STATE REGISTRAR			CERTIFICATE OF DEATH					
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR			
FIRST MIDDLE LAST Maxine Belle EAKLE			MONTH DAY YEAR May 15, 1980		M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		
Female		White		MONTH DAY YEAR Dec. 3, 1918		61 YRS.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		U.S.A.				Washington MD.		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Hagerstown		Coffman Home for the Aging				Home		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		
Md.		Wash.		Boonsboro		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		13e STREET ADDRESS				
FIRST MIDDLE LAST Joseph Franklin Eakle		FIRST MIDDLE LAST Mary K. McDowell		Route 1				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS		
no		-		212-94-5785		Mr. Richard L. Eakle, Hagerstown, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adeno Carcinoma</u> <u>1552</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adeno Carcinoma of liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>1 yr</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
<input type="checkbox"/>		HOUR A.M. MONTH DAY YEAR P.M. 19						
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (the hospital) attended the deceased from <u>Dec 21</u> , 19 <u>79</u> , to <u>April 15</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>April 14</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE				DEGREE		22c DATE SIGNED		
<u>Clayton A. Hoffman</u>				M.D.		5/16/80		
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS				
<u>Lloyd A. Hoffman</u>				<u>1147 Oak Hill Ave.</u>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		
Burial		May 18, 1980		St. Paul's Lutheran Cemetery		Leithersburg, Wash., Md.		
24 FUNERAL DIRECTOR'S NAME				25 DATE RECEIVED BY REGISTRAR		26 REGISTRAR'S SIGNATURE		
<u>Dennis Davis</u> Davis Funeral Home, Smithsburg, Md.				MAY 22 1980		<u>Richard L. Eakle</u>		

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

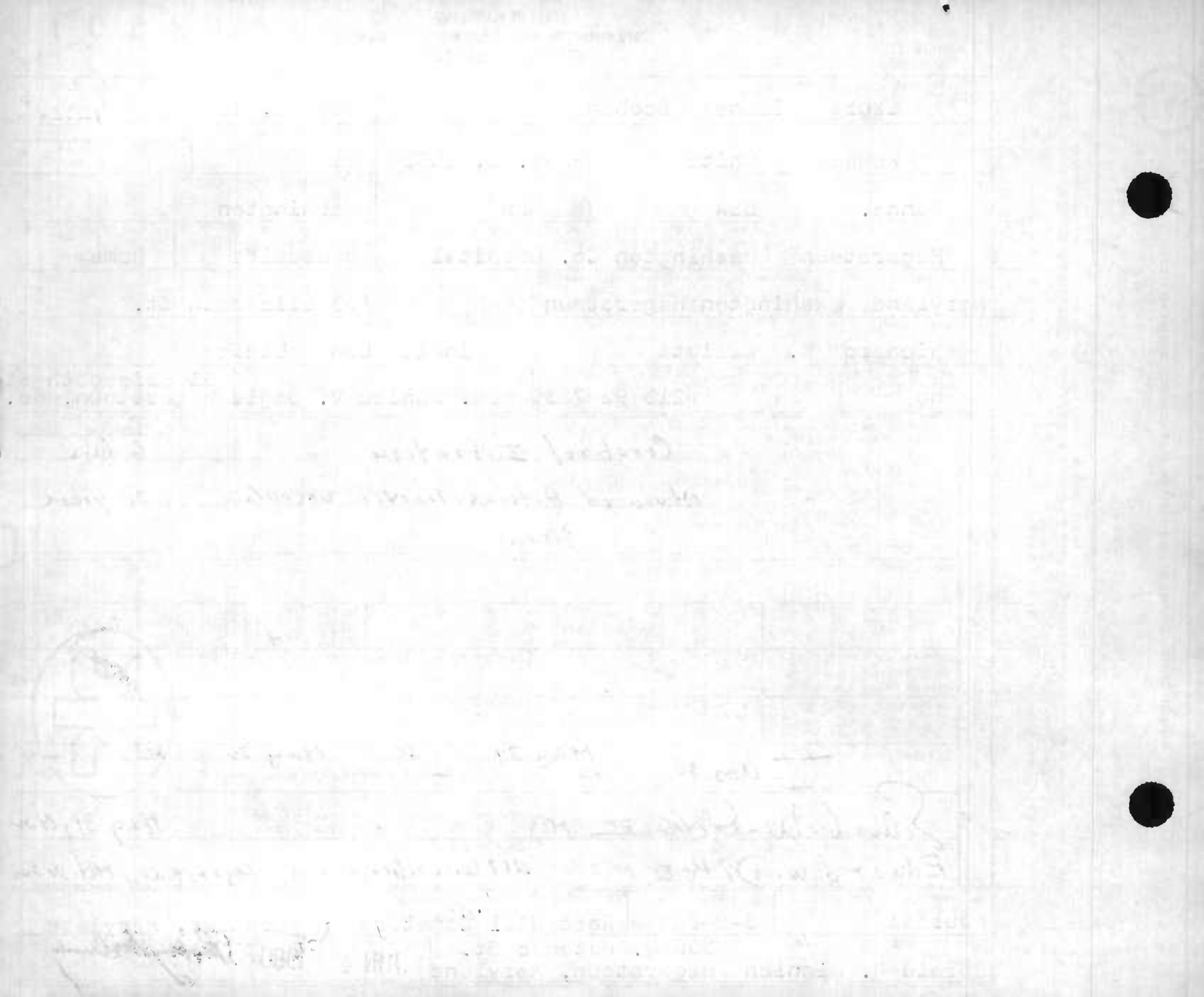
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Laura Irene Ecobona			2a. DATE OF DEATH MONTH DAY YEAR May 30, 1980		2b. HOUR 12:20 P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 3, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	12b. KIND OF BUSINESS OR INDUSTRY home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 33 Elizabeth St.	
14. FATHER'S NAME FIRST MIDDLE LAST Richard K. Elliott			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Lena Lidie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213 92 7219		17. INFORMANT ADDRESS Mrs. Janice V. Sagle 31 Elizabeth St. Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Cerebral Infarction</u> 4349 DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Advanced Atherosclerotic vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <u>Dissecting</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>20 years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>May 24</u> , 19 <u>80</u> to <u>May 30</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>May 30</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Edward W. Dittus II, MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>May 31, 1980</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward W. Dittus II, MD		22e. ADDRESS 217 W. Washington St. Hagerstown, Md 21240			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-2-80	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Maryland
24. FUNERAL DIRECTOR NAME Gerald N. Minnich		ADDRESS 305 N. Potomac St. Hagerstown, Maryland		25a. DATE REC'D. BY REGISTRAR JUN 4 1980	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

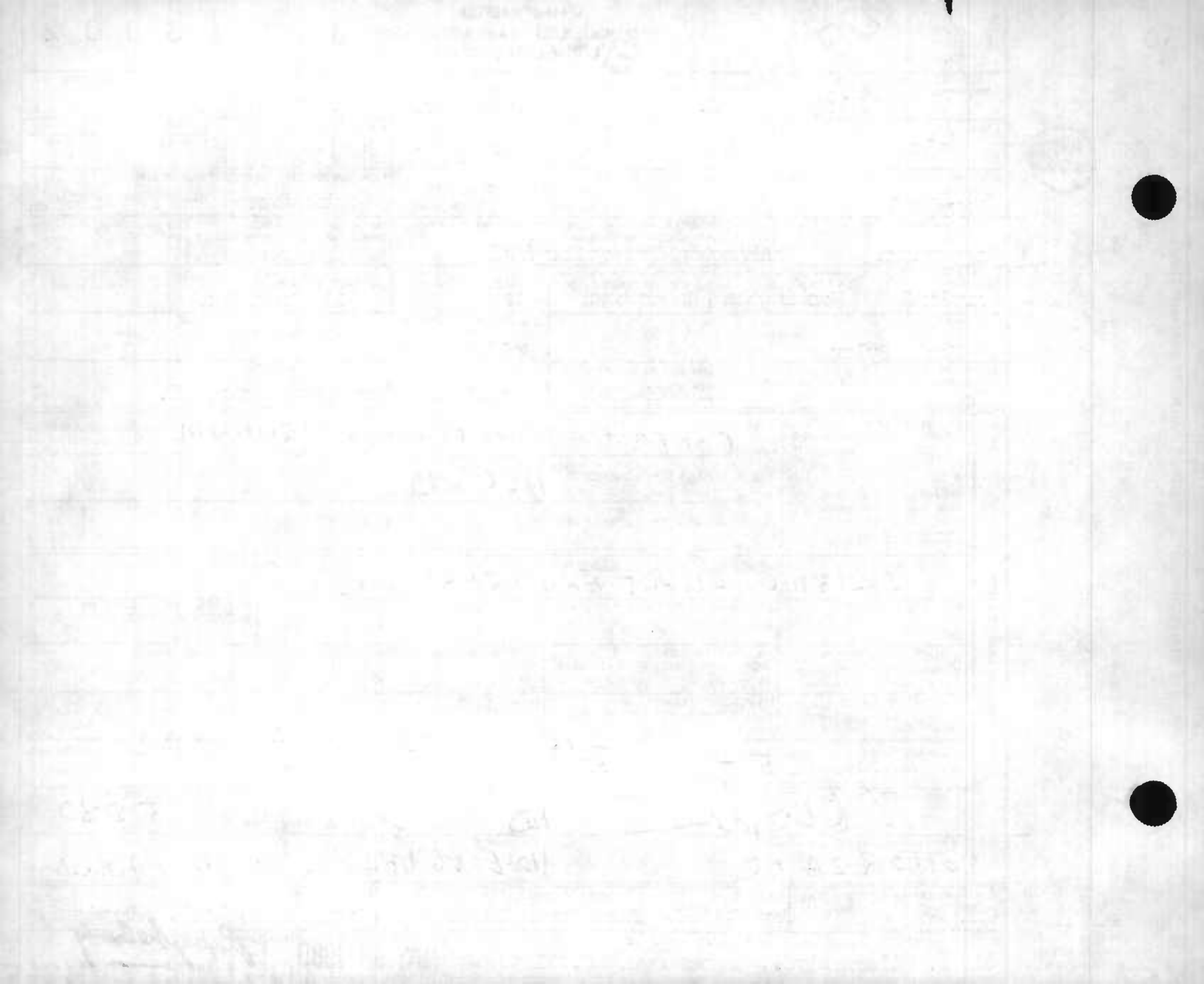


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 0 1 3 8 0 2			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lloyd C. EYLER, Sr.				2a. DATE OF DEATH MONTH DAY YEAR May 4, 1980				2b. HOUR M			
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR October 23, 1909		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) foreman		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 316 Avon Road	
14 FATHER'S NAME FIRST MIDDLE LAST Merle Eyler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Seldon Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-09-9082		17 INFORMANT ADDRESS Mabel E. Eyler, Hagerstown, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE + PNEUMONIA 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) SYSTEMIC LUPUS ERYTHEMATOSUS											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4.16.19.73 to 5.4.80, that (I) (we) last saw the deceased alive on 5.4.80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5.5.80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OTTO ROZA MD				22e. ADDRESS 100 LONG MEADOW DRIVE HAGERSTOWN							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE May 7, 1980		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME						24b. ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR MAY 9 1980		25b. SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 3 8 0 3

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
Walter Stanley Eyler		May 30, 1980	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Male	White	April 1, 1899	81
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Washington
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown	Avalon Manor Nursing Home	machinists	Pangborn
13a. STATE		13b. COUNTY	13c. CITY OR TOWN
Maryland	Washington	Hagerstown	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Adam Norwood Eyler		Bessie Estella Arnsperger	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
no			
17. INFORMANT		ADDRESS	
Ronald Eyler		236 Peacock Trail Hagerstown, Maryland	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Pulmonary Disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			?
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>5-4</u> , 19 <u>78</u> , to <u>5-30</u> , 19 <u>80</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>5-29</u> , 19 <u>80</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> did (did not) view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
<u>Lloyd A. Hoffmann</u>		<u>5/30/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
<u>Lloyd A. Hoffmann</u>		<u>1147 Oak Hill Ave - Hagerstown, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		6-2-80	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Rose Hill Cemetery		Hagerstown, Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Gerald N. Minnich Hagerstown, Maryland		25b. REGISTRAR'S SIGNATURE	
		<u>[Signature]</u>	

JUN 10 1980

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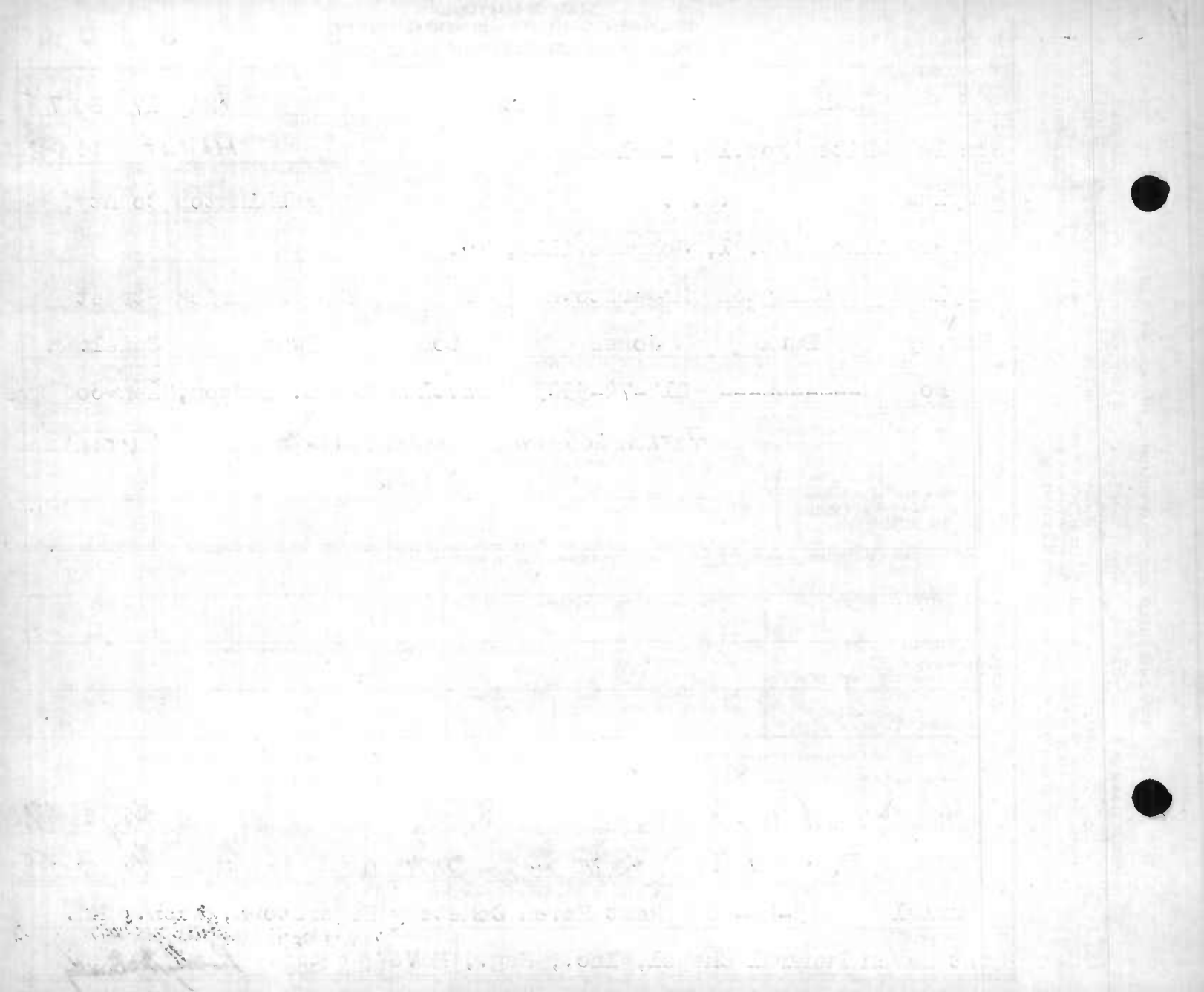
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME 15)  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		7. 0 1 3 8 0 4	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leah May Faith			
2a. DATE KNOWN OF DEATH ESTIMATED May 17 19 80		2b. HOUR 7 15 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH YEAR Nov. 18, 1891	6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.	
10. CITY OR TOWN OF DEATH Rohrersville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1, Rohrersville, Md.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. CITY OR TOWN Washington	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 223 Frederick Street	
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Burk Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lou Emma Spielman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-74-9505	
17. INFORMANT Mrs. Claudine S. Hudson		ADDRESS 1200 Glenwood Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Edward W. Dittus III</u>		TITLE (SPECIFY) M.D. <u>Deputy</u> MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) <u>Edward W. Dittus III, MD</u>		DATE SIGNED May 20, 1980	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-20-80	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Rest Haven Funeral Chapel, Inc., Hag.,		25a. DATE REC'D. BY REGISTRAR MAY 23 1980	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO. 8013805							
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR		
James Kreps FOCKLER			May 8, 1980				12:30 <sup>P</sup>			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
male		white		April 11, 1904		76 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA				Washington MD.				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown		Washington County Hospital				horse trainer		race track		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland		Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		23 Woodside Drive, Route 3		
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Leroy Mitchell Fockler					FIRST MIDDLE LAST Emma Bell Kreps					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS			
No					220-30-8899		Mildred Fockler, Hagerstown, Md.			
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident, thrombotic</u> <u>4340</u> <u>stroke</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral atherosclerosis</u> years DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 23 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertensive cardiovascular disease.</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/11/80</u> , 19____, to <u>5/8/80</u> , 19____, that (I) (we) last saw the deceased alive on <u>5/8/80</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) not view the body after death.										
27b. SIGNATURE <u>W. T. Layman, M.D.</u>					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED 5/9/80	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) W. T. Layman, M.D.					27e. ADDRESS 301 E. Antietam St., Hagerstown, MD.					
23a. BURIAL, CREMATION, REMOVAL burial			23b. DATE May 10, 1980		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clear Spring, Wash., Maryland			
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740					25a. DATE REC'D. BY REGISTRAR MAY 14 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR <b>Mary Keedy Fockler</b>									
1a DECEASED NAME (TYPE OR PRINT) <b>MARY KEEDY FOCKLER</b>					2a DATE OF DEATH <b>5-24-80</b>			2b HOUR <b>M</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>Nov. 24, 1895</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.			
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Colton Villa Nursing Home</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Sheriff's Dept</b>	
13a STATE <b>Maryland</b>		13b COUNTY <b>Washington</b>		13c CITY OR TOWN <b>Hagerstown</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>234 North Potomac Street</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Martin Luther Keedy</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nellie Cameron Stitt</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>212-38-8667</b>		17 INFORMANT <b>Robert A. Keedy</b> ADDRESS <b>1040 Columbia Road Hagerstown, Md. 21740</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHF</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Gen Arterio sclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>m</b> <b>m</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Anemia</b>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET <b>1600 OAK HILL AVE, HAGERSTOWN, MD</b>		CITY OR TOWN		COUNTY STATE	
22 I certify that (I) (this hospital) attended the deceased from <b>12-13, 1979</b> to <b>5-24, 1980</b> , that (I) (we) last saw the deceased alive on <b>5-20, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Vasant Datta</b> MD					DEGREE		22c DATE SIGNED <b>5-26-80</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>VASANT DATTA, M.D.</b>					22e ADDRESS <b>1600 OAK HILL AVE, HAGERSTOWN, MD</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>5-27-80</b>		23c NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			23d LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, Md.</b>		
24 FUNERAL DIRECTOR NAME ADDRESS <b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>					25a DATE REC'D. BY REGISTRAR <b>MAY 28 1980</b>				
					25b REGISTRAR'S SIGNATURE <i>Mary Keedy</i>				

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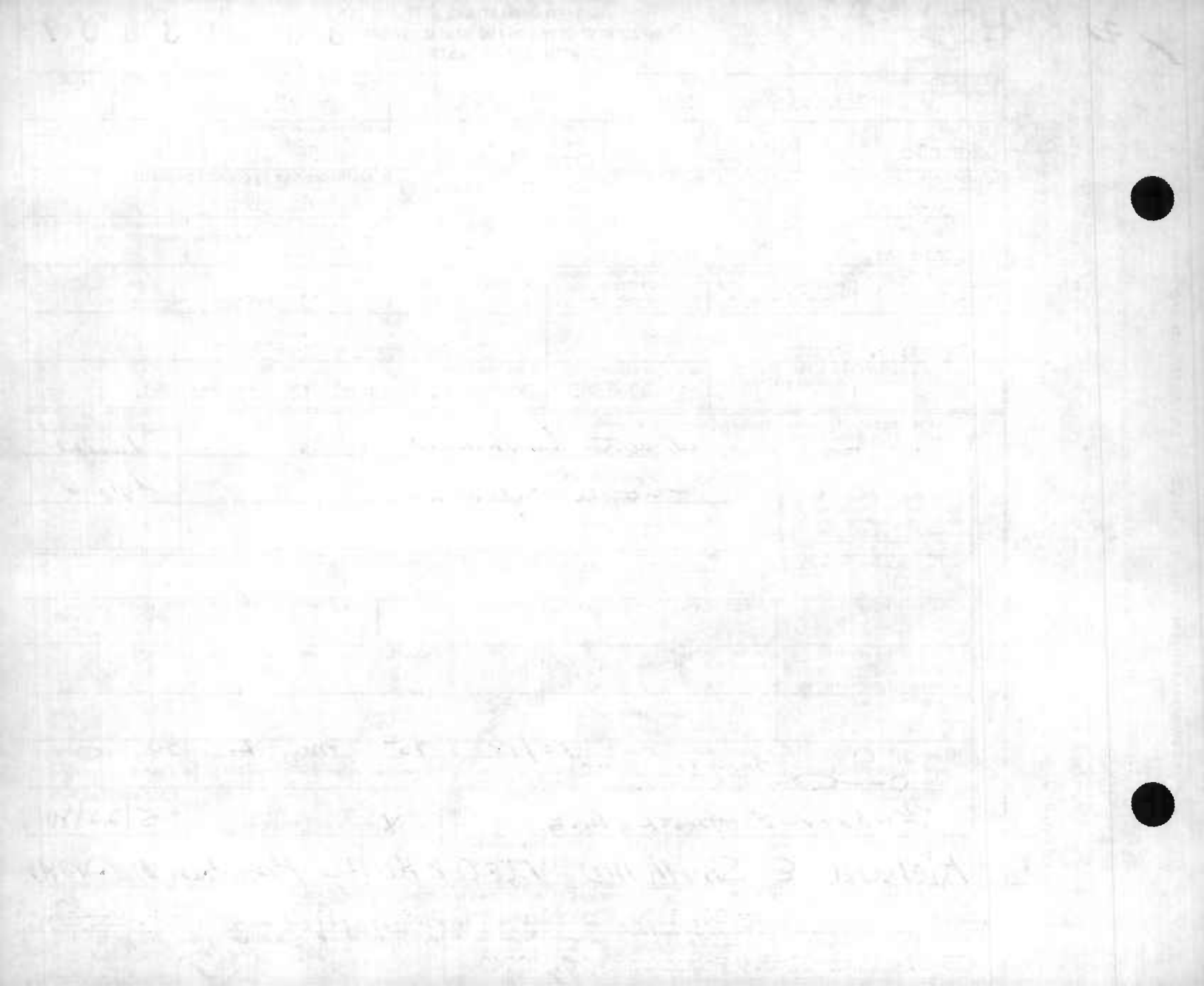
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 1 3 8 0 7				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Genevieve Dorothy GOSSARD					2a. DATE OF DEATH May 22, 1980			2b. HOUR M	
3. SEX female		4. RACE white		5. DATE OF BIRTH June 24, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (# NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) nurse		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 11 Decker Avenue	
14. FATHER'S NAME George W. Koontz				15. MOTHER'S MAIDEN NAME Minnie Dorothy Straitiff					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-20-2543		17. INFORMANT ADDRESS Howard E. Gossard, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute leukemia</u> 2030 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>multiple myeloma</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>4 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (if at this hospital) attended the deceased from <u>12/18</u> 19 <u>75</u> to <u>May 22</u> 19 <u>80</u> , that (I) (we) lost <u>saw the deceased alive on May 21 19 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above <u>(I) (we) did not view the body after death.</u>									
22b. SIGNATURE <u>Richard E. Smith, M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/22/80</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Richard E. Smith, MD</u>					22e. ADDRESS <u>1708 Oak Hill Ave Hagerstown, Md 21740</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE May 24, 1980		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Williamsport, Wash., Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740					25. DATE REC'D. BY REGISTRAR MAY 27 1980		25b. REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>		



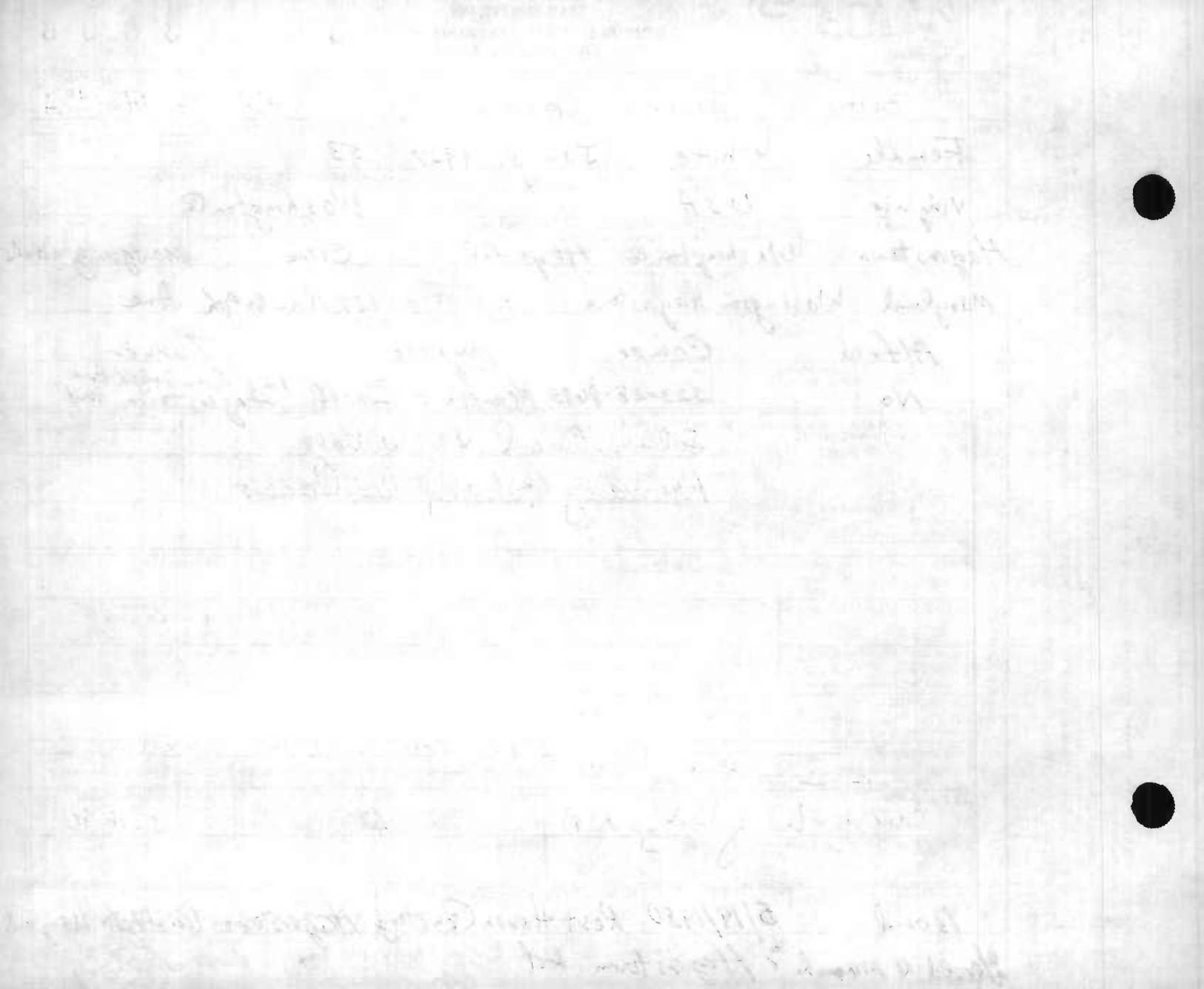
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 3 8 0 8			
1. FOR STATE REGISTRAR					REG. NO.								
I. DECEASED NAME (TYPE OR PRINT) <b>Bettie Jane Gouff.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 16 1980</b>			2b. HOUR <b>9:45 A.M.</b>					
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Jan. 5, 1927</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington Co.</b> MD.						
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Co. Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clack</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Montgomery Ward</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>127 Randolph Ave</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alfred Comer</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Myrtle Turner</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>223-28-8685</b>		17. INFORMANT <b>Kenneth E. Gouff.</b>					ADDRESS <b>127 Randolph Ave Hagerstown Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b> <b>430-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Primary Biliary Cirrhosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>5-14</b> 19 <b>80</b> to <b>5-16</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>5-16</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (do not) view the body after death.													
22b. SIGNATURE <b>Curry W. Gouff.</b>					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>5-16-80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5/19/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Washington Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Gerard H. Minnick</b>					ADDRESS <b>Hagerstown Md</b>			25a. DATE REC'D. BY REGISTRAR <b>MAY 22 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Barbara K. Brady</b>			







TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13809	
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE LULA LAST GREEN										2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR May 4 19 80										2b. HOUR OF DEATH 3:25 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 2-24 00 80		6. AGE (IN YEARS LAST BIRTHDAY) 2-24 00 80 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD May 4 19 80		2d. HOUR 3:25 P.M.							
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.									
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Own Home									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STREET ADDRESS Rfd. 10 Box 25											
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
14. FATHER'S NAME FIRST Noah MIDDLE LAST Souders					15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE LAST																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 214-74-1139					17. INFORMANT Mrs. Jane D. Line, Rfd. 10 Box 25 Hagerstown, Md. 21704											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4273 IMMEDIATE CAUSE (a) Cerebrovascular accident 436 DUE TO, OR AS A CONSEQUENCE OF (b) Atrial fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death 24 hrs. years																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION 4/30/80					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? left hip fracture - insertion of Austin Moore prosthesis					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. Apr 21 1980					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY) patient fell at home											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home					21f. LOCATION STREET CITY OR TOWN COUNTY STATE Beaver Creek Hagerstown Wash. MD											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE Harold R. Tritch, Jr.					TITLE (SPECIFY) M.D. Asst. Deputy					DATE SIGNED 5/5/80											
EXAMINER'S NAME (TYPE OR PRINT) Harold R. Tritch, Jr., M.D.					ADDRESS 138 E. Antietam St. Hagerstown, MD																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 5-8-80					23c. NAME OF CEMETERY OR CREMATORY Mt. Lena Cemetery					23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Lena, Wash. Co., Md.						
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.					ADDRESS Boonsboro, Md. 21713					25a. DATE REC'D. BY REGISTRAR MAY 8 1980					25b. REGISTRAR'S SIGNATURE [Signature]						

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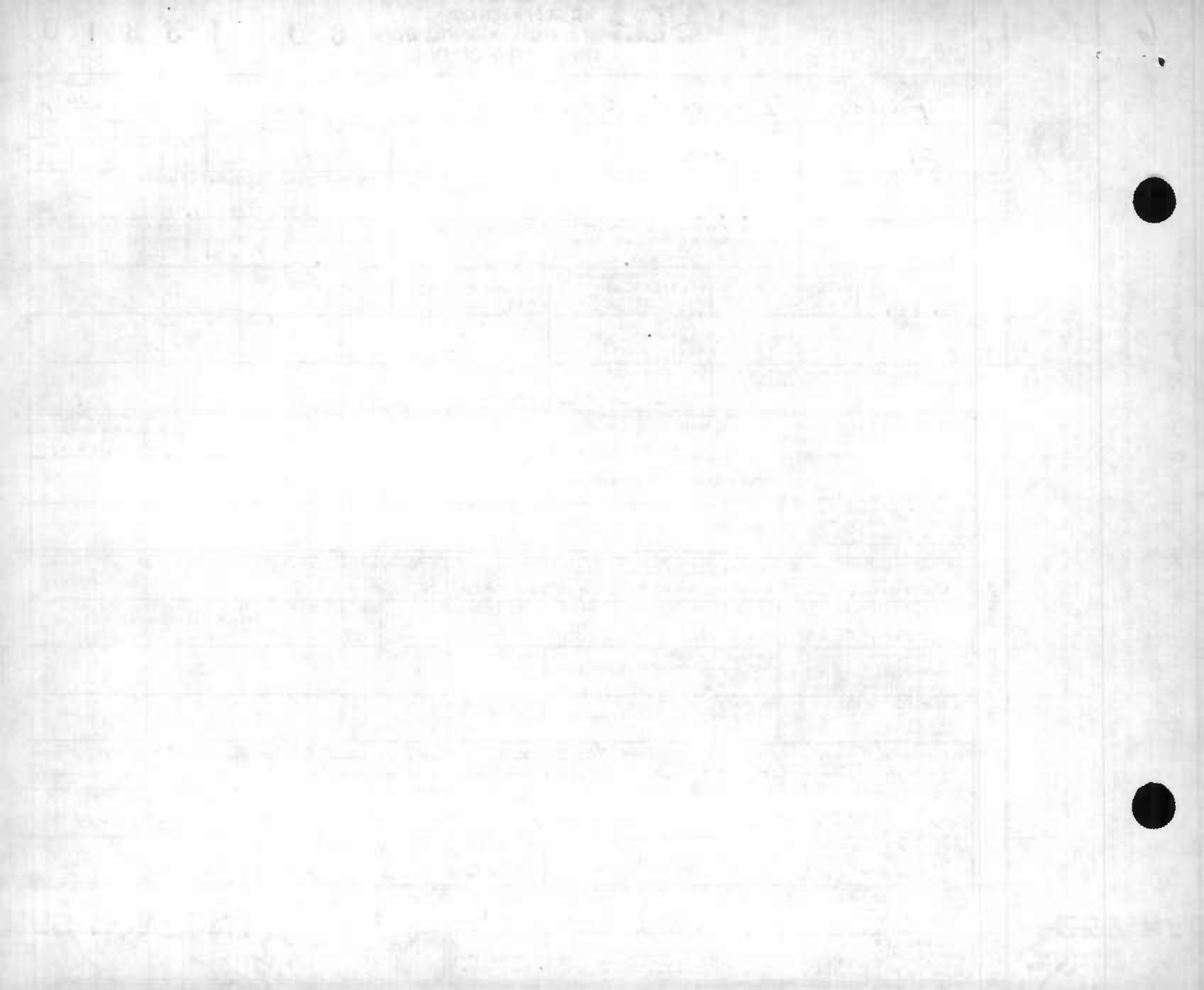
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 0 1 3 8 1 0	
1. FOR STATE REGISTRAR			REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>FRANK LINDSAY GREENWALT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 16 80</b>		2b. HOUR <b>5<sup>20</sup> PM</b>	
3. SEX <b>M</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 10 1890</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Fayetteville</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington Co.</b> MD.		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Co. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Const. Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Aviation</b>	
13a. STATE <b>EX. Md.</b>			13b. COUNTY <b>Fredrick</b>	13c. CITY OR TOWN <b>Blue Ridge Summit</b>	13d. INSIDE CITY LIMITS? <b>NO</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Lee Greenwalt</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Taylor</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>172-12-3178-A</b>		17. INFORMANT ADDRESS <b>Lindsay Collins Blue Ridge Summit Pa.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PNEUMONITIS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, SEVERE</b>						
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (1) (this hospital) attended the deceased from <b>APRIL 28</b> , 19 <b>80</b> , to <b>MAY 16</b> , 19 <b>80</b> , that (1) (we) lost saw the deceased alive on <b>MAY 16</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5-16-80</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARRY M. COHEN</b>		22e. ADDRESS <b>1198 KENLY AVE HAGERSTOWN, MD, 21740</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 20, 1980</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Norland Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Greensboro Franklin Co. Pa.</b>	
24. FUNERAL DIRECTOR NAME <b>Robert G. Sellers</b>		ADDRESS <b>Chambersburg Pa. 17201</b>		25. MAY 16 1980 BY REGISTRAR'S SIGNATURE		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13811	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Charles none Grove</b>										2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> <b>May 7 1980</b>	
3. SEX <b>male</b>	4. RACE <b>cauc.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 19, 1925</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>54</b>	IF UNDER 1 YR. MONTHS DAYS <b>54</b>	IF UNDER 24 HRS. HOURS MIN. <b>1:00</b>	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>May 9, 1980</b>		2d. HOUR <b>1:00</b>		P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S..A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b>		MD.			
10. CITY OR TOWN OF DEATH <b>Hancock</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. #2</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hancock</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. #2</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles C. Grove</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lottie V. Keefer</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>219 20 0885</b>		17. INFORMANT ADDRESS <b>Wilma C. Mitchell Rt. #2 Hancock, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>8809</b> IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage</b> N- 853 DUE TO, OR AS A CONSEQUENCE OF <b>skull fracture</b> (b) <b>Fall down stairs</b> E-880 DUE TO, OR AS A CONSEQUENCE OF (c) <b>acute alcoholism</b> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>acute alcoholism</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>11:00 May 7, 1980</b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11:00 May 7, 1980</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fall down stairs</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>house</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Hallow Rd Wash. Md.</b>			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Harold R Tritch</b>				TITLE (SPECIFY) <b>deputy</b>				MEDICAL EXAMINER DATE SIGNED <b>May 10, 1980</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Harold R Tritch, Jr., M.D.</b> ADDRESS <b>138 East Antietam St. Hagerstown, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>5-13-80</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Stone Bridge Brethren</b>			
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hancock Washington Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 13 1980</b>				25b. REGISTRAR'S SIGNATURE <b>Jeffrey M. Chedy</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Richard D. Grove Hancock MD.</b>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 3 8 1 2	
FOR 1. STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Raymond Willard Hart</i>					2a. DATE OF DEATH MONTH DAY YEAR May 9, 1980			2b. HOUR M			
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR October 10, 1905		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) operator		12b. KIND OF BUSINESS OR INDUSTRY Pangborn Corp.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 53 West Side Avenue		
14 FATHER'S NAME FIRST MIDDLE LAST Arthur G. Hart					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Beard						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 705-10-5910		17 INFORMANT ADDRESS Josephine L. Hart, Hagerstown, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Colon with wide spread metastasis</i> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <i>3/31/80</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of Colon</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>3/20/80</i> to <i>5/9/80</i> , that (I) (we) last saw the deceased alive on <i>5/9/80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>C. C. Su</i>					DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>5/9/80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>C. C. Su</i>					22e. ADDRESS <i>239 N. Potomac St. Hagerstown</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE May 12, 1980		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
24 FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>					24b. ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740			25a. DATE REC'D. BY REGISTRAR MAY 14 1980			

5-1-80

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C. 20250

TO :

FROM :

SUBJECT :

REFERENCE :

REMARKS :

DATE :

TIME :

LOCATION :

WEATHER :

WIND :

WAVE :

REMARKS :

MAY 1 1980



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
REG. NO. 8 0 1 3 8 1 3										
1. DECEASED NAME (TYPE OR PRINT) <b>Mary CAROLINE HEBNER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>May 12 1980</b>					2b. HOUR <b>7:55 A.M.</b>
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOVEMBER 26, 1913</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>66 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD.				
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON COUNTY HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>HANCOCK</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>ROUTE # 1</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD NMI HEBNER</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA NMI SHAW</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>213 92 5610</b>		17 INFORMANT ADDRESS <b>MRS. RUTH M. PRICE RT. 8 CUMBERLAND, MD.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Amphotrophic Lateral Sclerosis</b> 3352 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>May 6th 1980 to May 12 1980</b>						
22a. I certify that (if in this hospital) attended the deceased from <b>May 6th 1980</b> to <b>May 12 1980</b> , that (we) lost saw the deceased alive on <b>May 12 1980</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.										
22b. SIGNATURE <b>Robert Brull</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>May 16 1980</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Brull</b>		22e. ADDRESS <b>1198 Newly Ave Hagerstown, Md 21740</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5/15/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BUCK VALLEY U.C.C.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WARFORDSBURG, FULTON, PENNA.</b>				
24. FUNERAL DIRECTOR NAME <b>Richard D. Lowe</b>		ADDRESS <b>Hancock MD</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 26 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>				

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8013814			
1. FOR STATE REGISTRAR		REG. NO.											
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
Harry Thurman		Henson Jr.						May 22, 1980					M
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		June 5, 1935		44		MONTHS		DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				Washington							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Washington County Hospital		Laborer		Kline Construc.							
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS					
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		124 E. Franklin St.					
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME											
Harry Thurman		Blanche Lillian Griffith											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS							
no		214-34-0982		Blanche Henson		124 E. Franklin St. Hager., MD							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>										1 day			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										1 day			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u>													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Acute Pericardial Disease</u>													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from <u>2-13-</u> 19 <u>78</u> , to <u>5-22</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5-21-</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE		DEGREE		22c DATE SIGNED									
Vasant Datta, MD				5-27-80									
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS											
1600 OAK HILL AVE VASANT DATTA, M.D.		1600 OAK HILL AVE, HAGERSTOWN, MD 21740											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE							
Burial		May 27, 1980		Cedar Lawn Cemetery		Hagerstown Washington MD							
24 FUNERAL DIRECTOR NAME		24b ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE							
Osborne Funeral Home		P.O. Box 348 Wmspt., MD		JUN 13 1980		P. J. Brady							



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 3 8 1 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Austin Lee HIGHBERGER				2a. DATE OF DEATH MONTH DAY YEAR May 31, 1980		2b. HOUR 12:00 PM	
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 5, 1925		6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Aircraft	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN Maryland Washington Sharpsburg				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 108 W. Main St.	
14 FATHER'S NAME FIRST MIDDLE LAST Leonard Eugene Highberger				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Caroline Reilly			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO _____		17 INFORMANT ADDRESS Mrs. Frances Williams 128 Calvert Terrace Hagerstown, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 410- DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIO VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) SLIDEN							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SLIDEN
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHRONIC OBSTRUCTIVE LUNG DISEASE, OBESITY							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/4 1969 to 5/31 1980, that (I) (we) lost saw the deceased alive on 5/31 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE MD		22c. DATE SIGNED 6/2/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. AMARILLO				22e. ADDRESS 127 KING ST HAGERSTOWN MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 3, 1980		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sharpsburg Washington Maryland	
24 FUNERAL DIRECTOR NAME Major M. Osborne				ADDRESS Widdowson, MD.		25a. DATE BY REGISTRATION JUN 13 1980	



CHRONIC OBSTRUCTIVE LUNG DISEASE (COPD)  
DISEASE  
HYPERLIPIDEMIA (HIGH CHOLESTEROL)  
GOITRISM (THYROID DISEASE)

15. IN ALKALOID  
13.8%  
12.5%  
11.5%  
10.5%  
9.5%  
8.5%  
7.5%  
6.5%  
5.5%  
4.5%  
3.5%  
2.5%  
1.5%  
0.5%

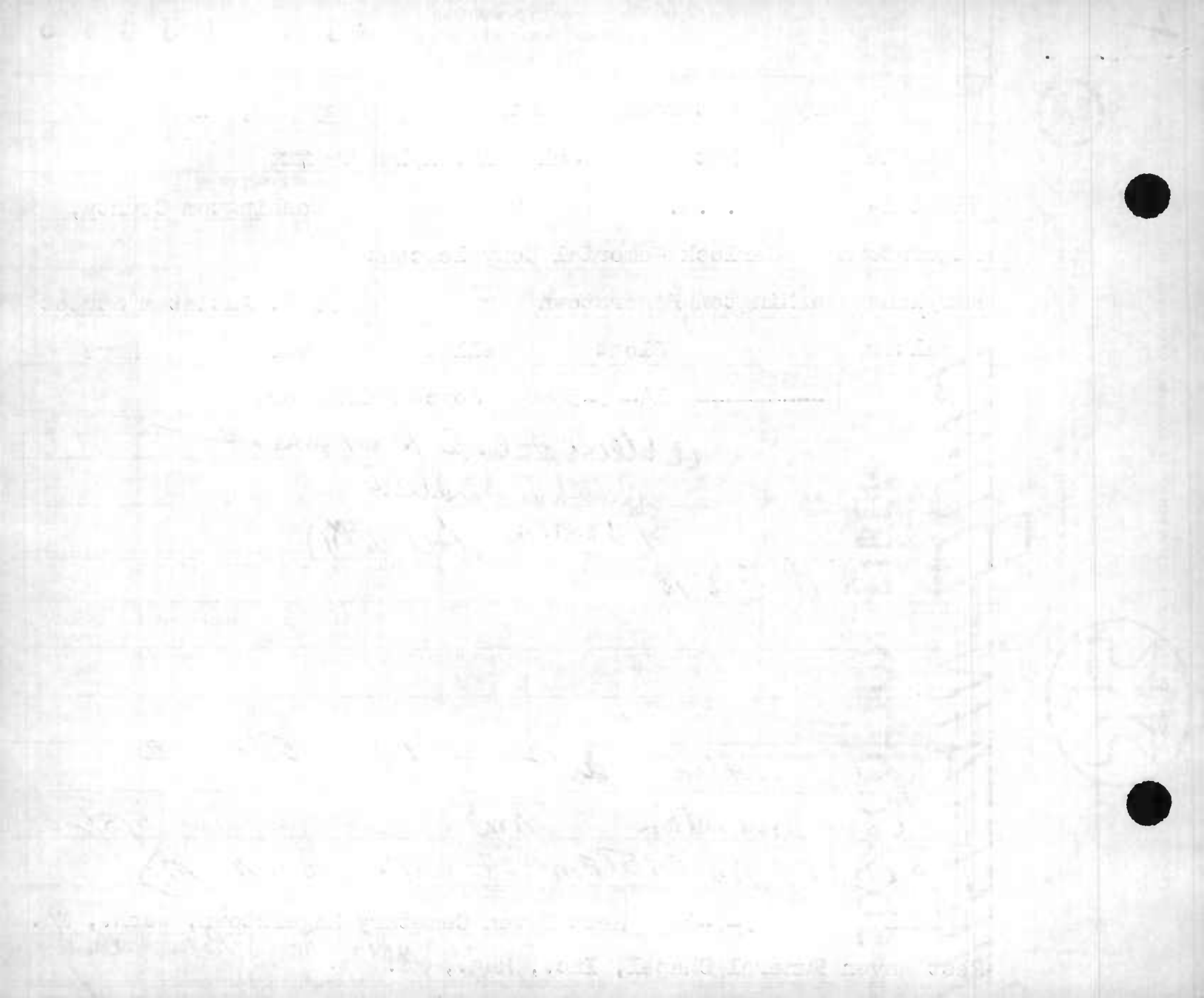
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires; that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1 - FOR STATE REGISTRAR					8 0 1 3 8 1 6					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
FIRST MIDDLE LAST					MONTH DAY YEAR					
Mary Carson Hines					May 6, 1980					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR		
Female		White		July 10, 1910		69 <del>70</del> YRS		M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia		U.S.A.				Washington County, MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								
Hagerstown		Garlock Memorial Convalescent								
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS	
Maryland					Washington		Hagerstown		59 E. Antietam Street	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Walter Sloat					Nellie Wood Nave					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No					214-09-5680		Joyce Mullendore			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF <u>Gangrene of Left Arm</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Old CVA</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>6-15</u> , 19 <u>67</u> , to <u>5/6</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4/4</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE <u>Admy Rosenstein</u>					22c. DATE SIGNED <u>5/8/80</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SIDNEY NOVENSTEIN</u>					22e. ADDRESS <u>FUNKS WALK</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		5-9-80		Rest Haven Cemetery		Hagerstown, Wash., Md.				
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Rest Haven Funeral Chapel, Inc., Hag., Md.					MAY 1, 1980		<u>Anthony McCurdy</u>			

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. REG. NO.				8 0 1 3 8 1 7			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jerome William HOFFMASTER					2a. DATE OF DEATH MONTH DAY YEAR May 31, 1980			2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 24, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
12. CITY OR TOWN OF DEATH Hagerstown		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 323 West Wilson Blvd.				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		15. KIND OF BUSINESS OR INDUSTRY C. Electric	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Washington Hagerstown					17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS 323 W. Wilson Blvd.		
19. FATHER'S NAME FIRST MIDDLE LAST Thomas A. Hoffmaster					20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Lewis				
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		22. SOCIAL SECURITY NO 216-14-6339		23. INFORMANT ADDRESS Mrs. Virginia Hoffmaster, Hagerstown, Md.					
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiorespiratory failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Severe indigestion</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Significant Coronary</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) <i>Specific Interval Between Onset and Death</i>									
25. DATE OF OPERATION <i>we</i>		26. CONDITION FOR WHICH OPERATION WAS PERFORMED				27. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
32. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		34. LOCATION STREET CITY OR TOWN COUNTY STATE					
35. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
36. SIGNATURE <i>[Signature]</i>				37. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		38. DATE SIGNED			
39. PHYSICIAN'S NAME (TYPE OR PRINT)				40. ADDRESS					
41. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		42. DATE June 3, 1980		43. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		44. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
45. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740						46. DATE REC'D. BY REGISTRAR JUN 6 1980		47. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

331A  
Cable to Washington  
from  
London  
June 10

BBB

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 3 8 1 8			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>ERNEST F. HOOVER</b>				2a DATE OF DEATH MONTH DAY YEAR <b>MAY 24 1980</b> 2b HOUR <b>9:30 A.M.</b>			
3 SEX <b>male</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Jan. 20, 1894</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Avalon Manor Nursing Home</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Principal</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS			
13a STATE <b>Md.</b>		13b. CITY OR TOWN <b>Smithsburg</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>Rt. 3</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Charles C. Hoover</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Linnie Leckrone</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b SOCIAL SECURITY NO <b>215-20-7804</b>		17 INFORMANT ADDRESS <b>E. Randall Hoover, Smithsburg, Md.</b>			
16a. (IF YES, GIVE WAR OR DATES) <b>WW I</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4275</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Carcinoma of prostate; senile dementia</b>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4/14 1980</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) ( <del>the</del> hospital) attended the deceased from <b>4/14</b> 19 <b>80</b> to <b>5-24</b> 19 <b>80</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>5-22</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.							
22b. SIGNATURE <b>Clark A. Hoffman</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/24/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Clark A. Hoffman</b>				22e. ADDRESS <b>214 N. Potomac St</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>		23b. DATE <b>May 28, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Mausoleum</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg Wash Md</b>	
24 FUNERAL DIRECTOR NAME <b>Dennis L. Davis</b> ADDRESS <b>Davis Funeral Home, Smithsburg, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 20 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey McBrady</b>	

ERNEST F. COVER

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Wolfgang A. Hoffmann

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				2b. HOUR			
Eva Madeline HOPKINS		May 20, 1980				M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS	
female	white	March 3, 1906		74		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Washington MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington County Hospital				nurse			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
Maryland		Washington		Hagerstown		YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME				16. STREET ADDRESS			
Arthur McCauley		Emma Grace Heck				1743 Edgewood Hill Circle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
No				James C. Hopkins, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral vascular accident</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>FEB 25</u> 19 <u>79</u> to <u>5/20/</u> 19 <u>80</u> , that (I) (we) lost <u>5/20/</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
W. Wooster MD									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
WOOSTER		1825 Aowell RD AAGS - NW							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
burial		May 23, 1980		Cedar Lawn Mem. Park		Hagerstown, Wash., Maryland			
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
MINNICH FUNERAL HOME		MAY 27 1980				[Signature]			
415 E. Wilson Blvd., Hagerstown, Md. 21740									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 0 1 3 8 2 0			
1. FOR STATE REGISTRAR			REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) John William HOWARD, JR.			2a DATE OF DEATH MONTH DAY YEAR May 26, 1980		2b HOUR 3 P.M. M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 20, 1923		6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.		
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b KIND OF BUSINESS OR INDUSTRY Farming		
13a STATE Maryland			13b CITY OR TOWN Frederick		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d STREET ADDRESS 6918 Potomac Avenue	
14 FATHER'S NAME FIRST MIDDLE LAST John William Howard Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Holter					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) none		17 INFORMANT Mrs. Irma Howard, 6918 Potomac Avenue Frederick, Md. 21701			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Arrest</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>METASTATIC BRAIN TUMOR</u> (c) <u>Adenocarcinoma of the Colon</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and I do not) view the body after death.								
22b SIGNATURE <u>J. P. Carey, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 5/27/80		
22d PHYSICIAN'S NAME (TYPE OR PRINT) J. P. Carey, M.D.				22e ADDRESS 1190 MT Aetna Rd Hagerstown Md.				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE May 29, 1980		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.		
24 FUNERAL DIRECTOR Small, Fadelley, Keeney, Bassard Funeral Home 106 East Church St., Frederick, Md. 21701				25a DATE REC'D. BY REGISTRAR JUN 2 1980		25b REGISTRAR'S SIGNATURE <u>Anthony A. Brady</u>		



Adenocarcinoma of the Colon  
Metastatic Brain Tumor  
Radio-Respiratory Arrest

J.P. Carey, M.D.  
J.P. Carey, M.D.

1100 Mt. Airy Rd. Harrison, N.J.  
2/22/72



BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13821	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>HERBERT LEE HOWELL</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>MAY 15 1980</b>		2b. HOUR <b>6<sup>08</sup> PM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 3, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>MAY 17 1980</b>		2d. HOUR <b>11<sup>04</sup> PM</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>157 South Mulberry Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Watchman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School Board</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>157 South Mulberry Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Howell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>236-28-5678</b>		17. INFORMANT <b>Phyllis A. Bowman</b>		ADDRESS <b>154 South Mulberry St., Hagerstown, Md. 21740</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4292 Congestive Heart Failure #428</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>20 years</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Edward W. Ditto III</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>MAY 18, 1980</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Edward W. Ditto III, MD</b>				ADDRESS <b>212 W. Wash. St. Hagerstown, Md 21740</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>5-18-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematorium</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg, Washington, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 27 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Jeffrey McBrady</i>			

Male White, Jan. 2, 1901

10-10-50

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 3 8 2 2	
1 - STATE REGISTRAR				CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE PATRICIA LAST INGRAM				2a. DATE OF DEATH MONTH DAY YEAR May 22 1980				2b. HOUR 6 20 A M			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR April 5 1932		6 AGE (IN YEARS LAST BIRTHDAY) 48 YRS YRS		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.					
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Presser		12b KIND OF BUSINESS OR INDUSTRY Clothing Mills			
13a STATE Maryland				13b COUNTY Washington		13c CITY OR TOWN Dargan		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS Route , Box 197 Harpers Ferry, W V 25425	
14 FATHER'S NAME FIRST MIDDLE LAST Alvie Sindney Stouts				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene ? Waters							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. 215-28-8280		17 INFORMANT ADDRESS Route 1, Box 197 Howard L. Ingram - Harpers Ferry, W V 25425					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Adeno-CARCINOMA LEFT BREAST 7 YEARS DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MOS.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION Sept. 1978				19b CONDITION FOR WHICH OPERATION WAS PERFORMED Adeno-ca LEFT BREAST				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (the hospital) attended the deceased from Sept 19 78, to MAY 22 19 80, that (I) (we) lost saw the deceased alive on May 22 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE John A. Moran				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 5/22/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN A. MORAN M.D.				22e ADDRESS 215 N. WASHINGTON ST., HAGERSTOWN, MD							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 5/25/80		23c NAME OF CEMETERY OR CREMATORY Samples Manor Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Samples Manor, Wash., Md.			
24 FUNERAL DIRECTOR NAME Robert L. Spencer - Harpers Ferry, W V 25425				ADDRESS P. O. Box 446		25a DATE REC'D. BY REGISTRAR JUN 2 1980		25b REGISTRAR'S SIGNATURE [Signature]			



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 3 8 2 3		
1. FOR STATE REGISTRAR					CERTIFICATE OF DEATH							
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR		
FIRST MIDDLE LAST Roy (NMN) JOHNSON					MONTH DAY YEAR 6-5-80					6:44p M		
3 SEX M		4 RACE CAUC		5 DATE OF BIRTH MONTH DAY YEAR 6 11 92		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.						
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY Farming				
13a. STATE MD					13b. COUNTY WASH		13c. CITY OR TOWN BIG POOL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS BOX 44, RT 1	
14 FATHER'S NAME FIRST MIDDLE LAST Stillwell Johnson					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Gordon							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 220-34-0903		17 INFORMANT ADDRESS Mr. Harry Johnson Clearspring, Md.								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN YEARS												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from 19 76, to 19 80, that (1) (we) last saw the deceased alive on APRIL 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.												
22b. SIGNATURE Barry M. Cohen MD		DEGREE		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN				22c. DATE SIGNED 6-1-80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY M. COHEN		22e. ADDRESS HAGERSTOWN, MD, 21740										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 3, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.						
24. FUNERAL DIRECTOR (TYPE OR PRINT) Thompson Funeral Home		25a. DATE REC'D. BY REGISTRAR JUN 4 1980		25b. REGISTRAR'S SIGNATURE [Signature]								

*James M. Thompson*

Barry at Center

*[Signature]*

WHEATON, MD 21340  
1125 KENNEDY AVE

8-1-60

NOTE

RECEIVED AT THE FRONT DESK  
JAN 1 1961

MR. BARRY  
MR. BARRY  
MR. BARRY

MR. BARRY  
MR. BARRY  
MR. BARRY

MR. BARRY  
MR. BARRY  
MR. BARRY



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>Lorie</b>		MIDDLE <b>ANN</b>		LAST <b>JONES</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>MAY 23</b> 19 <b>80</b>		2b. HOUR <b>2:00</b> P M	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>Sept.</b> DAY <b>27</b> YEAR <b>1961</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>18</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>MAY 23</b> 19 <b>80</b>		2d. HOUR <b>2:17</b> P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON Co.</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Co. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nursing</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Penna.</b>		13b. COUNTY <b>Franklin</b>		13c. CITY OR TOWN <b>Waynesboro</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6022 Anthony Highway</b>			
14. FATHER'S NAME FIRST <b>Max</b> MIDDLE <b>I.</b> LAST <b>Jones</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Edith</b> MIDDLE <b>G.</b> LAST <b>Nunemaker</b>				16. SOCIAL SECURITY NO. <b>209-52-7678</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>209-52-7678</b>		17. INFORMANT <b>Max I. Jones</b>				ADDRESS <b>6022 Anthony Highway Waynesboro, Pa.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MOTOR VEHICLE/MOTOR VEHICLE COLLISION</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>APPROX. 2 HRS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <b>1:30</b> AM. MONTH <b>MAY</b> DAY <b>23</b> YEAR <b>1980</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>MOTORCYCLE COLLISION WITH TRUCK WITH MULTIPLE MASSIVE SYSTEM INJURIES.</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>STAMY ROAD</b>		21f. LOCATION STREET <b>NEAR MT. ALTO,</b> CITY OR TOWN <b>FRANKLIN,</b> COUNTY <b>PENNA.</b> STATE <b>PENNA.</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Edward W. Ditto</i>		M.D. <b>DEPUTY</b> MEDICAL EXAMINER <b>217 WEST WASHINGTON STREET</b>				DATE SIGNED <b>MAY 23, 1980</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>		ADDRESS <b>HAGERSTOWN, MARYLAND</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/27/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Mont Alto</b> COUNTY <b>Franklin</b> STATE <b>Pa.</b>			
24. FUNERAL DIRECTOR <i>David H. Shore</i>		ADDRESS <b>50 S. Broad St. Waynesboro, Pa.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 29 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Harvey M. Brady</i>					

ST. LOUIS, MO.

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WASHINGTON, D.C.

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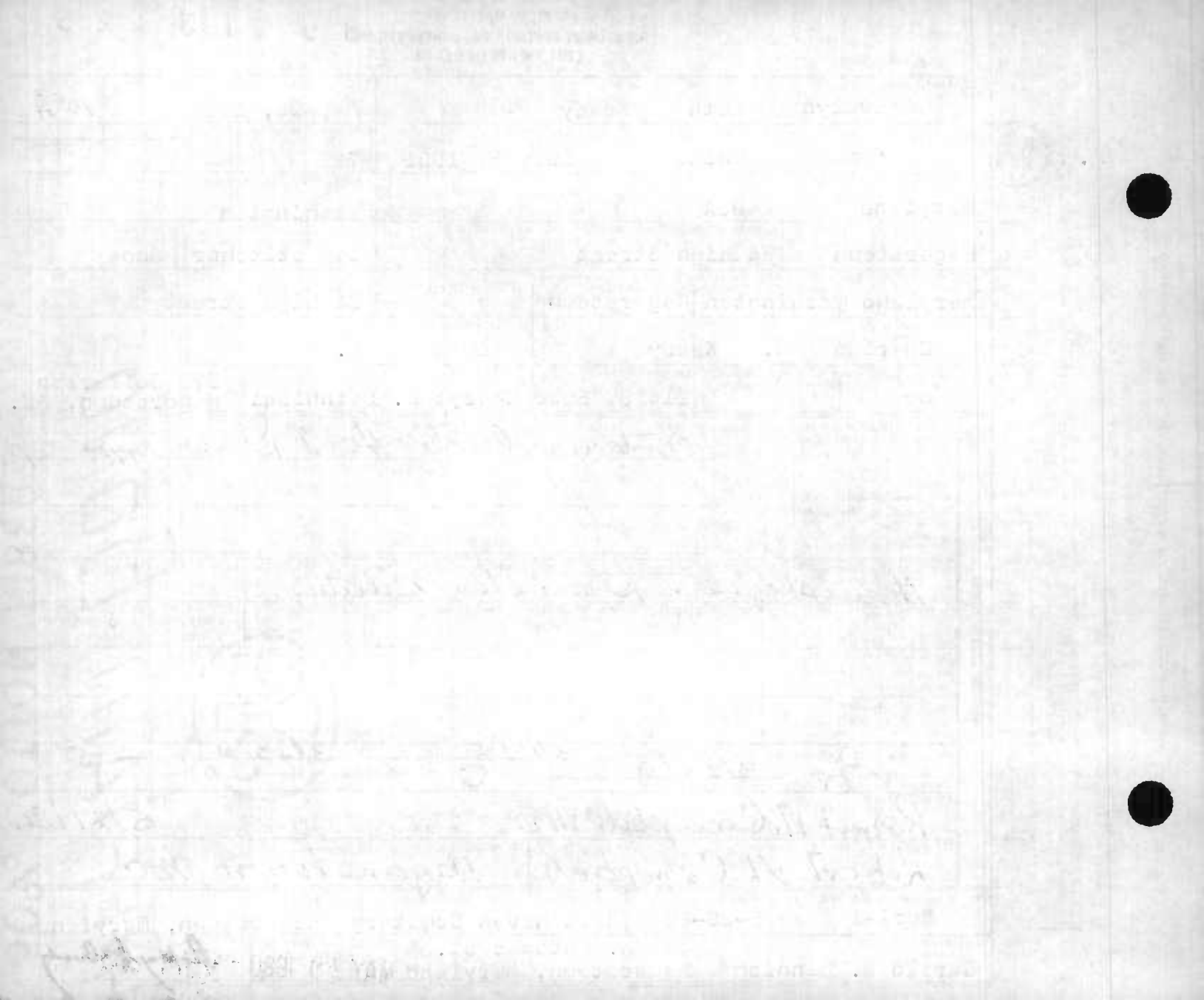
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified if possible.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		6013825							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Evelyn Ruth Keedy								May 26, 1980	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		July 5, 1901		78 YRS		IF UNDER 24 HRS	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Maryland		USA				Washington MD.		top stitcher shoe	
13. CITY OR TOWN OF DEATH		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		16. INSIDE CITY LIMITS?		17. STREET ADDRESS	
Hagerstown		34 High Street		Maryland Washington Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		34 High Street	
18. FATHER'S NAME		19. MOTHER'S MAIDEN NAME		20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		21. SOCIAL SECURITY NO.		22. INFORMANT ADDRESS	
Charles N. Keedy		Emma E.		no		214 09 5086		570 Jefferson Hagerstown, Md.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>approx 10y</u>									
4140 DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hemiplegia. Diabetes Mellitus.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		19 P.M.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>3/18/80</u> , 19____, to <u>3/23/80</u> , 19____, that (1) (we) last saw the deceased alive on <u>3/23/80</u> , 19____, and that in (2) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Robert H. Campbell MD						5/27/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Robert H. Campbell		Hagerstown Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		5-28-80		Rest Haven Cemetery		Hagerstown, Maryland			
24. FUNERAL DIRECTOR NAME		305 N. Potomac St.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Gerald N. Minnich		Hagerstown, Maryland		MAY 29 1980		Robert H. Campbell			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					REG. NO.	
1- FOR STATE REGISTRAR					8013826	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		
FIRST MIDDLE LAST				MONTH DAY YEAR		
Mary Ellen Keedy				May 4, 1980		
3 SEX		4 RACE		5 DATE OF BIRTH		
Female		White		MONTH DAY YEAR		
				June 15, 1903		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6 AGE (IN YEARS LAST BIRTHDAY)		
Distric of Columbia		U.S.A.		76 YRS		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9 BALTIMORE CITY OR COUNTY OF DEATH		
Hagerstown		Colton Villa Nursing Home		Washington County		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Sales Clerk		Dress Shop				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a STATE		13b COUNTY		13c CITY OR TOWN		
Maryland		Washington		Hagerstown		
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST		FIRST MIDDLE LAST				
John H. Fitzgerald		Mary Battle				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		
No		---		Shirley A. Swam		
		214-09-0791		30 Virginia Avenue Shrewsbury, Pa. 17361		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)						
PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) CHF						
4409 DUE TO, OR AS A CONSEQUENCE OF Renal Failure						
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last Anterior sclerosis						
DUE TO, OR AS A CONSEQUENCE OF						
(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
Anemia, Rheumatoid arthritis						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		
				YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1-21-1980 to 5-4-1980, that (I) (we) last saw the deceased alive on 4-17-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Vasant Datta MD		22c. DATE SIGNED 5-5-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
VASANT DATTA, M.D.		1600 OAK HILL AVE, HAGERSTOWN				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		
Burial		5-7-80		Rose Hill Cemetery		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
A.K. Coffman Funeral Home, Inc., Hagerstown, Md.		MAY 9 1980		Anthony McCready		
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION CITY OR TOWN COUNTY STATE		
Hagerstown, Washington, Maryland						

1943, 1944

Wife John

70

June 15, 1945

White

Female

Washington County

U.S. of Columbia

John Clark

John Clark

Washington

John Clark

Washington

John Clark

Female

White

John Clark

John

10 Virginia Avenue  
Washington, D.C. 20001

U.S. of Columbia

John

John Clark

John Clark

John Clark

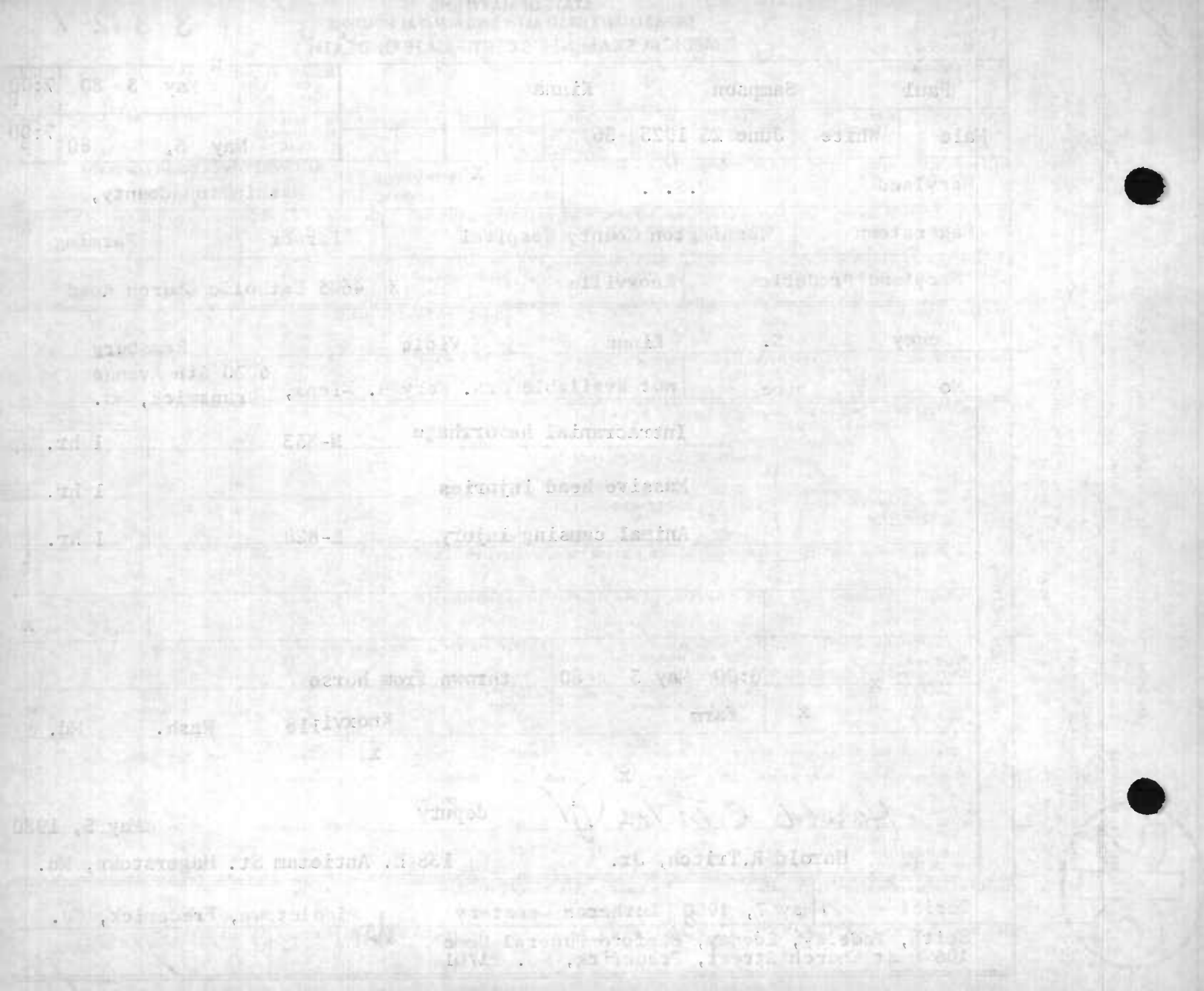
U.S. of Columbia

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH: 17  
(VR A15 ME (5))  
15M 7/77

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>Paul Sampson Kinna</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> <b>May 3, 1980</b>										2b. HOUR <b>7:00 P.M.</b>									
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>June</b> DAY <b>23</b> YEAR <b>1923</b>		6. AGE (IN YEARS) YRS. <b>56</b>		IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		2c. DATE PRONOUNCED DEAD MONTH <b>May</b> DAY <b>3</b> YEAR <b>1980</b>										2d. HOUR <b>7:00 P.M.</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County, MD.</b>																	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Washington County Hospital</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>											
13a. STATE <b>Maryland</b> COUNTY <b>Frederick</b> CITY OR TOWN <b>Knoxville</b>										13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS <b>4605 Catholic Church Road</b>																	
14. FATHER'S NAME FIRST <b>Dewey</b> MIDDLE <b>S.</b> LAST <b>Kinna</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Viola</b> MIDDLE <b>Ramsburg</b> LAST <b>Ramsburg</b>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES) <b>none</b>										16b. SOCIAL SECURITY NO. <b>not available</b>					17. INFORMANT ADDRESS <b>Mrs. Mary H. Kinna, 6020 6th Avenue, Brunswick, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage</b> N-853 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>828-</b> (b) <b>Massive head injuries</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Animal causing injury</b> E-828										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>1 hr.</b> <b>1 hr.</b>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6:00 P.M. May 3 1980</b>					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>thrown from horse</b>																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>farm</b>					21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Knoxville Wash. Md.</b>																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																													
ACTUAL SIGNATURE <b>Harold R. Tritch Jr.</b>										TITLE (SPECIFY) <b>deputy</b>										DATE SIGNED <b>May 5, 1980</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>Harold R. Tritch, Jr.</b>										ADDRESS <b>138 E. Antietam St. Hagerstown, Md.</b>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>May 7, 1980</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>					23d. LOCATION CITY OR TOWN COUNTY STATE <b>Middletown, Frederick, Md.</b>														
24. FUNERAL DIRECTOR NAME <b>Smith, Fadelley, Keeney, Basford</b> ADDRESS <b>106 East Church Street, Frederick, Md. 21701</b>										25a. DATE BY REGISTRAR <b>MAY 13 1980</b>										25b. REGISTRAR'S SIGNATURE <b>Harry H. Cuddy</b>									

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR	
		HAROLD BURNELL KISER		5-6-80	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Male		White		9-25-01	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Penna.		USA		78	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
HAGERSTOWN		AVALON MANOR Nursing Home		chief	
13a. STATE		13b. COUNTY		13c. STREET ADDRESS	
Maryland		Hagerstown		1.3 Fairground Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
William Russell Kiser		Grace Maybelle Butt		NO	
17. INFORMANT ADDRESS		18. SOCIAL SECURITY NO.		19. DATE OF OPERATION	
411 N. Colonial Drive Hagerstown, Md.		215 18 1694		19. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
YES <input type="checkbox"/> NO <input type="checkbox"/>				P.M. 19	
22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
YES <input type="checkbox"/> NO <input type="checkbox"/>					
22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
5/7/80		R. AMARILLO		127 KING ST HAGERSTOWN MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		5-8-80		Rest Haven Cem.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Gerald N. Minnich		MAY 13 1980		H. McCready	





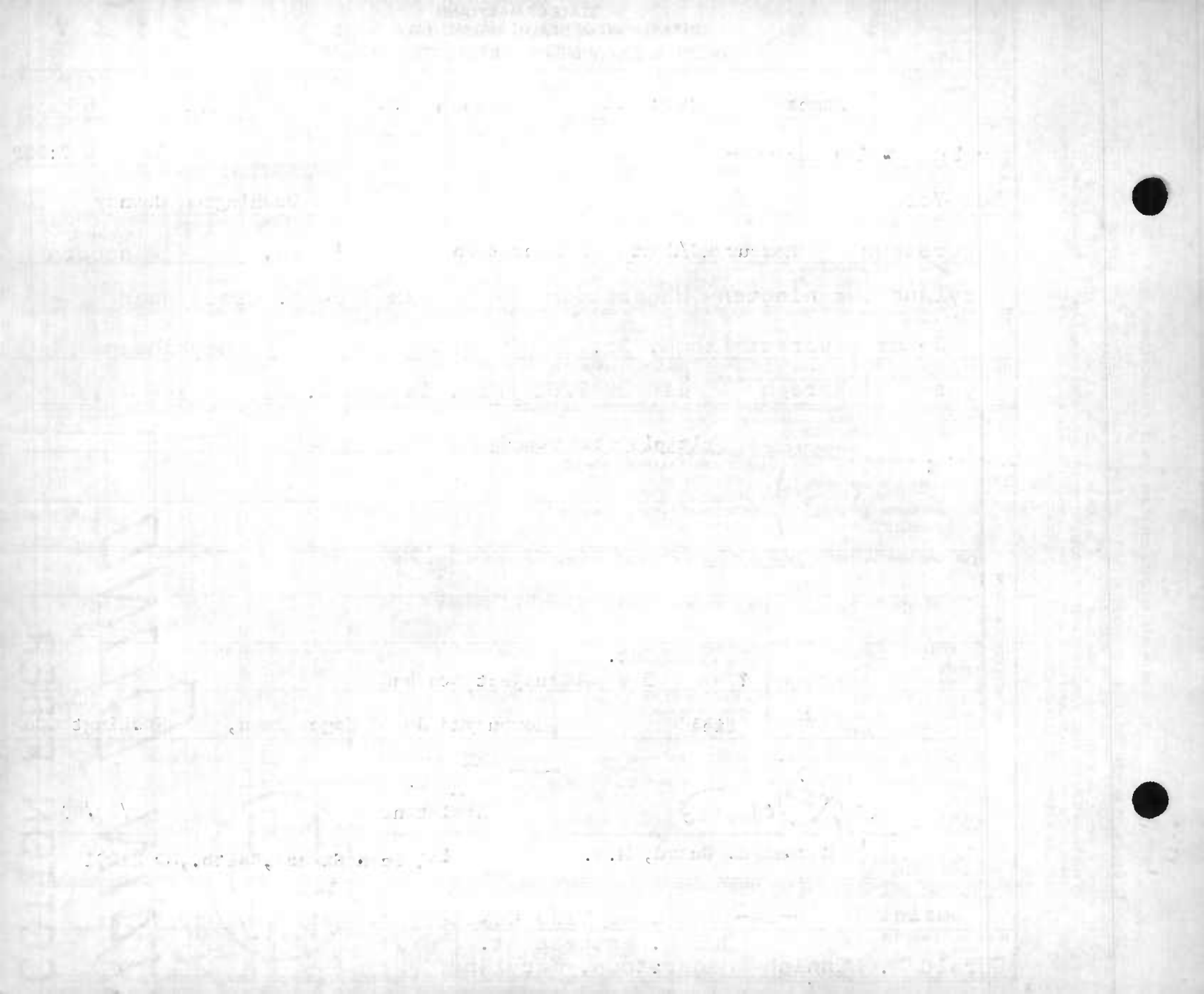
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13829					
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James Everett Klomp, Jr.										ESTIMATED MONTH DAY YEAR XX 5 9 1980		M			
3. SEX male		4. RACE white		5. DATE OF BIRTH (MONTH DAY YEAR) 2-21-30		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 19 1980		2d. HOUR 7:00P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RoxburyRd/South of Hagerstown				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) sl's ex.				12b. KIND OF BUSINESS OR INDUSTRY Pangborn			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2504 N. Crest Road							
14. FATHER'S NAME FIRST MIDDLE LAST James Everett Klomp, Sr.										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Hawkinson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. Korean		17. INFORMANT ADDRESS 118 22 7262				Mrs. Ielene J. Klomp see # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple stab wounds 966- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY (HOUR A.M. MONTH DAY) ? P.M. 5/9 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject stabbed									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) field		21f. LOCATION (CITY OR TOWN) RoxburyRd/So of Hagerstown, Washington Co MD				STATE					
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Hormez R. Guard, M.D.				TITLE (SPECIFY) Assistant				DATE SIGNED 5/20/80							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn Street, Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-24-80		23c. NAME OF CEMETERY OR CREMATORY Lake View Cemetery				23d. LOCATION (CITY OR TOWN) COUNTY STATE Jamestown, New York					
24. FUNERAL DIRECTOR NAME Gerald N. Minnich				ADDRESS 305 N. Potomac St. Hagerstown, Maryland				25a. DATE REC'D. BY REGISTRAR MAY 27 1980		25b. REGISTRAR'S SIGNATURE Anthony McCreedy					

MEDICAL CERTIFICATION



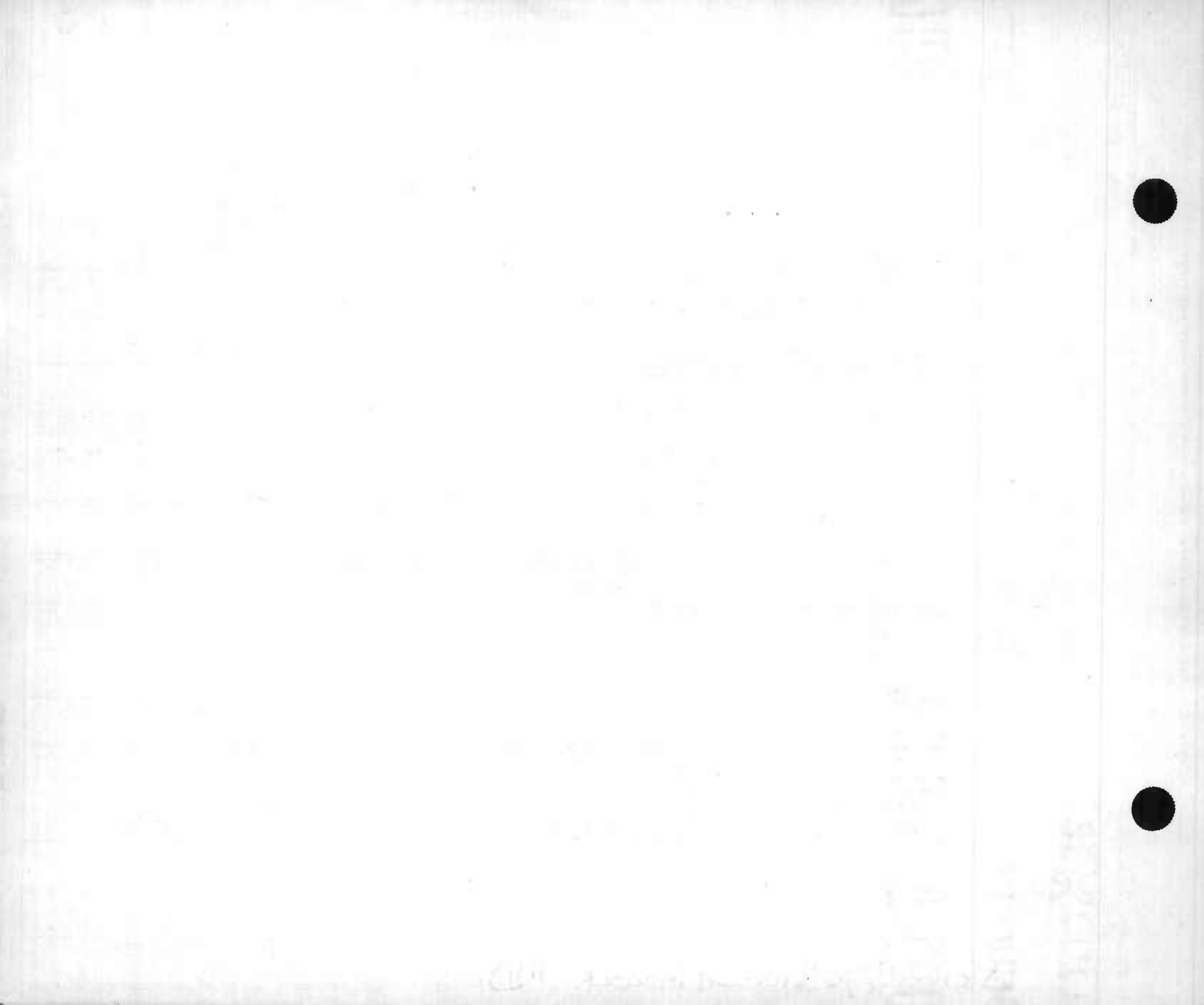
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 3 8 3 0			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
Mary Anne Knox				May 8 1980			
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 8 1980		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE Maryland				13b. CITY OR TOWN Hagerstown			
14. FATHER'S NAME Norman Lee Knox				15. MOTHER'S MAIDEN NAME Betty Diane Turner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) Newborn			
17. INFORMANT Mother				ADDRESS 618 W. Washington Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 7651 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Premature Labor</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 min.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>							
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>5/8/80</u> , 19____, to <u>5/9/80</u> , 19____, that (I) (we) lost saw the deceased alive on <u>5/8/80</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE <u>Pierre Asmar</u>				DEGREE <u>M.D.</u>		22c. DATE SIGNED 5/9/80	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Pierre Asmar, M. D.				22d. ADDRESS Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-10-80		23c. NAME OF CEMETERY OR CREMATORY Parkhead Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Big Pool Washington Md.	
24. FUNERAL DIRECTOR NAME Richard J. Thore				ADDRESS Hancock Md.		25a. DATE REC'D. BY REGISTRAR MAY 10 1980	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

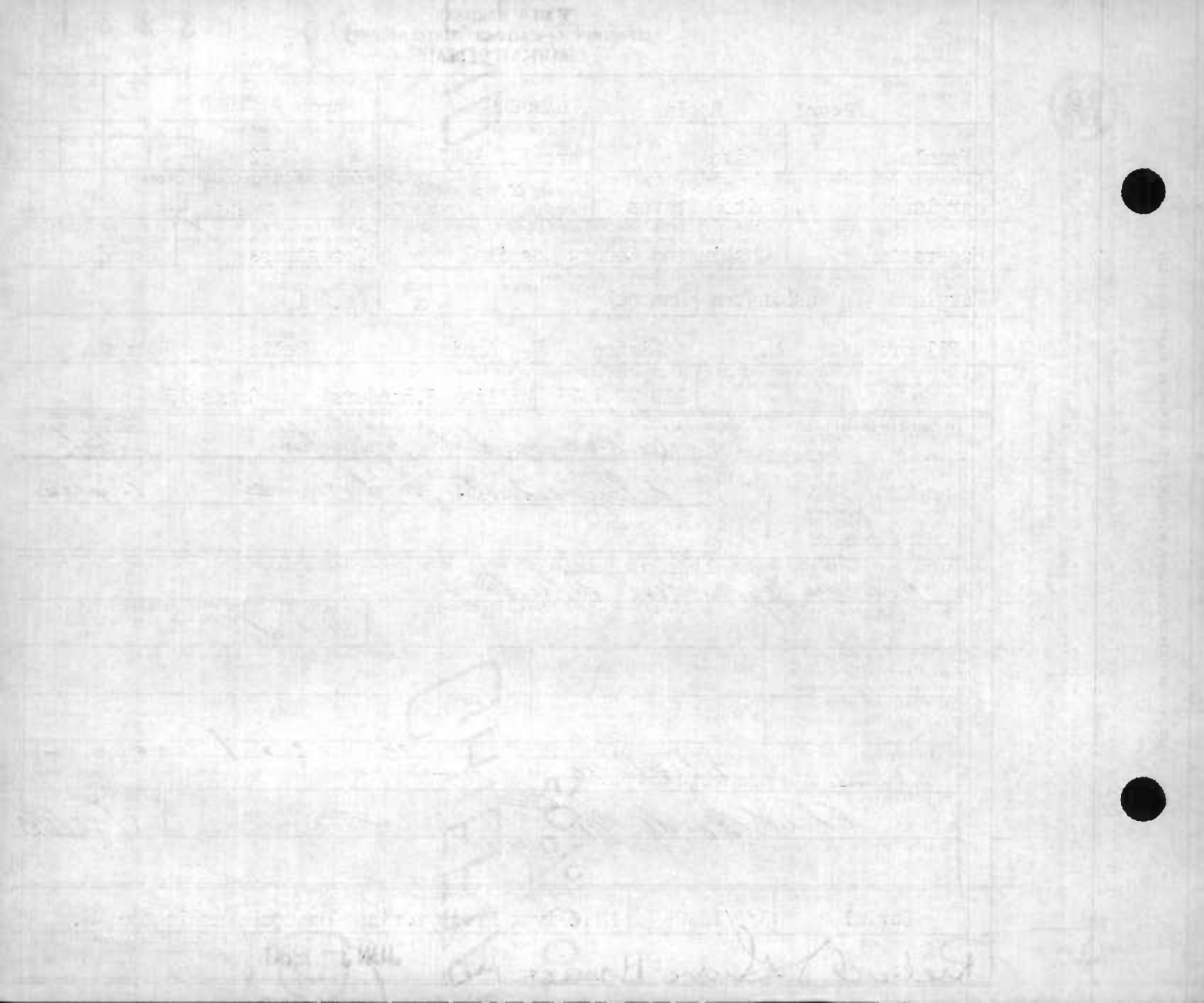
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Pearl Regina LANDERS					2a. DATE OF DEATH MONTH DAY YEAR March 2 1980				
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR March 22, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7b. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Clothing		
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hancock		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. # 1	
14. FATHER'S NAME FIRST MIDDLE LAST Filmore M. Bishop			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Belle Munson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219 20 4573		17 INFORMANT ADDRESS William J. Landers Sames 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>10 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Previous Myocardial Infarctions</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. certify that (I) (this hospital) attended the deceased from _____, 19 <u>70</u> , to <u>3/2/80</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>2/18/80</u> , 19 <u>80</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) ( <u>did not</u> ) view the body after death.									
22b. SIGNATURE <u>Edward Brady MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <u>5/27/80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/5/1980		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Presbyterian		23d. LOCATION CITY OR TOWN COUNTY STATE Hancock; Washington; Md.			
24. FUNERAL DIRECTOR NAME <u>Richard Delmore Hancock MD</u>				25a. DATE REC'D. BY REGISTRAR JUN 3 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP \_\_\_\_\_



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO. 13832									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
Paula		Kay		LAWRENCE				7. DATE KNOWN OF DEATH		8. MONTH		9. DAY		10. YEAR		11. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		10. MONTH		11. HOUR	
female		white		Oct. 21, 1951		28 YRS.		MONTHS		DAYS		HOURS		MIN.		2:45 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. NEVER MARRIED		10. WIDOWED		11. DIVORCED		12. BALTIMORE CITY OR COUNTY OF DEATH					
New York		USA		WIDOWED		NEVER MARRIED						Washington					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13. KIND OF BUSINESS OR INDUSTRY											
Hagerstown		Washington County Hospital		housewife													
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland		Washington		Hagerstown		YES		NO		526 Summit Avenue							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Paul G. Jones		Manzella Hicks															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		220-58-3531		Mr. David E. Lawrence, Jr.,		Hagerstown, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
IMMEDIATE CAUSE (a) E 950 - DRUG OVERDOSE - ELAVIL		1 - 2 HRS.															
9502		EST.															
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES		NO											
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
SELF ADMINISTERED OVERDOSE ELAVIL 75 MG. APPROXIMATELY 93 TABLETS		12:00 MAY 19 19 80															
21d. INJURY OCCURRED WHILE NOT WHILE AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
HOME		HOME		526 SUMMIT AVENUE,		HAGERSTOWN,		WASH.,		MD.							
22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection		Inquiry		and in my opinion									
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Edward W. Ditto III		DEPUTY		MAY 20, 1980													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
EDWARD W. DITTO, III, M.D.		217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
burial		May 22, 1980		Cedar Lawn Mem. Park		Hagerstown, Wash.,											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 0 1 3 8 3 3	
1- FOR STATE REGISTRAR			CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR
Reuben Daniel Leininger			5 13 80			12 <sup>35</sup> P.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR	
Male	Can.	4-26-36	44 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
Penna.	U.S.A.	9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown	Washington County Hospital		Supervisor		Manufacturing	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS	
13a. STATE Penna.			13b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. 781 Mickey Inn Lane	
14. FATHER'S NAME (FIRST MIDDLE LAST)			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)			
Reuben Daniel Leininger			Nellie Shore			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes			1954-1958		164-30-2900 Mrs. I.R. Leininger 781 Mickey Inn Lane, Chambersburg, Pa. 17201	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute heart failure</u> <u>1629</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Squamous Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 month.</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (a) (this hospital) attended the deceased from <u>5/13/80</u> 19 <u>80</u> to <u>5/13</u> 19 <u>80</u> , that (b) (we) last saw the deceased alive on <u>5/13</u> 19 <u>80</u> , and that in (c) (my) opinion death occurred on the date and hour and from the causes stated above. (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)						
22a. SIGNATURE <u>Richard E. Smith, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/13/80</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Richard E. Smith, M.D.</u>				22e. ADDRESS <u>1708 Oak Hill Ave., Hagerstown, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		May 16, 1980		Norland Cemetery		Franklin Co. Pa.
24. FUNERAL DIRECTOR NAME <u>John R. Ruck</u> ADDRESS <u>152 S. 2nd St. Chambersburg, Pa. 17201</u>				25a. DATE REC'D. BY REGISTRAR <u>MAY 19 1980</u>		25b. REGISTRAR'S SIGNATURE <u>Jeffrey McCreedy</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR					
John Calvin Long					May 10, 1980					
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR		
Male		White		Sept. 8, 1900		79 YRS.		M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.				Washington County MD.				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Williamsport		Williamsport Nursing Home				Laborer		Coal Company		
13a. STATE					13b. CITY OR TOWN		13c. STREET ADDRESS			
Maryland					Washington		Hagerstown			
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
John Luther Long					Mary Elizabeth McNamee					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17 INFORMANT			
Yes					W.W. II		Ruth G. Cassidy			
18 CAUSE OF DEATH Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) Pneumonia										
4409										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					(b) Arteriosclerosis					
DUE TO, OR AS A CONSEQUENCE OF					(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		STATE
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 5/11/80 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
Byrd D. Johnson					M.D.					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
Byrd D. Johnson M.D.					16005 Comas Rd., Clarksburg, Md 20734					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		5-13-80		Salem Reformed Church			Cearfoss, Washington, Md.			
24. FUNERAL DIRECTOR NAME					ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
A. K. Coffman Funeral Home, Inc., Hagerstown, Md							MAY 14 1980		[Signature]	

BP

3.  $\frac{1}{2}$

0020 95 4706

29

## INTRODUCTION

• • •

Figure 10

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND. 24-201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/77

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13835			
1. DECEASED NAME (TYPE OR PRINT) <b>Jessie B MAC Daniels</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>May 23, 1980</b>										2b. HOUR <b>5:40 PM</b>			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 15 1881</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>98</b>		IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>		2c. DATE PRONOUNCED DEAD <b>May 23 1980</b>										2d. HOUR <b>5:40 PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>WPSA/INGTON MD</b>											
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wash. Co. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE <b>Pa.</b>		13b. COUNTY <b>Franklin</b>		13c. CITY OR TOWN <b>Chambersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>218 Lincoln Way East</b>															
14. FATHER'S NAME FIRST MIDDLE LAST <b>Levi C. Brandt</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Sites</b>																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>					16b. SOCIAL SECURITY NO. <b>202-03-6535</b>					17. INFORMANT <b>20255 Scollard Ave. Mrs. Thomas Gamble Chambg. Pa. 17201</b>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (d) <b>E-880 Fall from Steps.</b> 8809 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>one week</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																							
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>					21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR <b>4:00 P.M. May 16 1980</b>					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fell on Steps at Local Boule</b>													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Bank</b>					21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Lincoln Way E. Chambersburg Franklin Pa.</b>													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <b>Edward W. Dittus III</b>					TITLE (SPECIFY) <b>Deputy</b>					DATE SIGNED <b>May 24, 1980</b>													
EXAMINER'S NAME (TYPE OR PRINT) <b>Edward W. Dittus III</b>					ADDRESS <b>212 W. Washington St. Hg. Md.</b>																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>5/27/80</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Norland Cemetery</b>					23d. LOCATION CITY OR TOWN COUNTY STATE <b>Greene Twp. Franklin Co. Pa.</b>								
24. FUNERAL DIRECTOR NAME ADDRESS <b>Robert G. Sellers 297 Phila. Ave. Chambg. Pa.</b>										25a. DATE REC'D. BY REGISTRAR <b>JUN 4 1980</b>					25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>								

RECEIVED  
FEB 10 1964  
U.S. AIR FORCE

TO: SAC, NEW YORK  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]

[illegible text]

[illegible text]

[illegible text]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR				8 0 1 3 8 3 6					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
Wilbur Lloyd Martin				May 7, 1980				7:30 A.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR	
Male		White		February 24, 1905		75 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Lemasters, Pa.		USA				Washington Co., MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington Co. Hosp.				Farmer-Carpenter		Bldg.	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE		13b COUNTY		13c CITY OR TOWN		13d STREET ADDRESS			
Pa.		Franklin		Mercersburg		4240 Lemar Rd.			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME					
Amos P. Martin				Annie Shelly					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO		17 INFORMANT			
No				203-10-5180		Mrs. Emma Martin 4240 Lemar Rd. Mercersburg, Pa.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ruptured left ventricle</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute myocardial Infarction</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR							
21d INJURY OCCURRED		21e PLACE OF INJURY		21f LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN COUNTY STATE			
22a I certify that (I) (the hospital) attended the deceased from <u>5/6</u> 19 <u>80</u> , to <u>5/7</u> 19 <u>80</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>5/7</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) (I did not) view the body after death.									
22b SIGNATURE				DEGREE				22c DATE SIGNED	
<u>George Newman II</u>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				May 8, 1980	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS					
George C. Newman, II, Ph.D., M.D.				1825 Howell Road, Hagerstown, MD 21740					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		STATE	
Burial		5/10/80		Montgomery Breth.		Montgomery Twp. Franklin Co., Pa.		Pa.	
24 FUNERAL DIRECTOR				ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
<u>John L. Linger</u>				Mercersburg, Pa.		MAY 16 1980		<u>John L. Linger</u>	



7:30

May 7, 1900

Martin

White

White

May 7, 1900

White

Washington Co.

x

USA

Lemaster, Pa.

Warner-Carpenter Bldg.

Washington Co. Bldg.

Washington

1430 Lemar Rd.

x

Franklin Mercersburg

Franklin

Pa.

Shelly

Annie

Martin

P.

Anne

1430 Lemar Rd.

203-10-2180 Mrs. Anne Martin Mercersburg, Pa.

Franklin Co., Pa.

Montgomery Bldg.

Initial

Mercersburg, Pa.

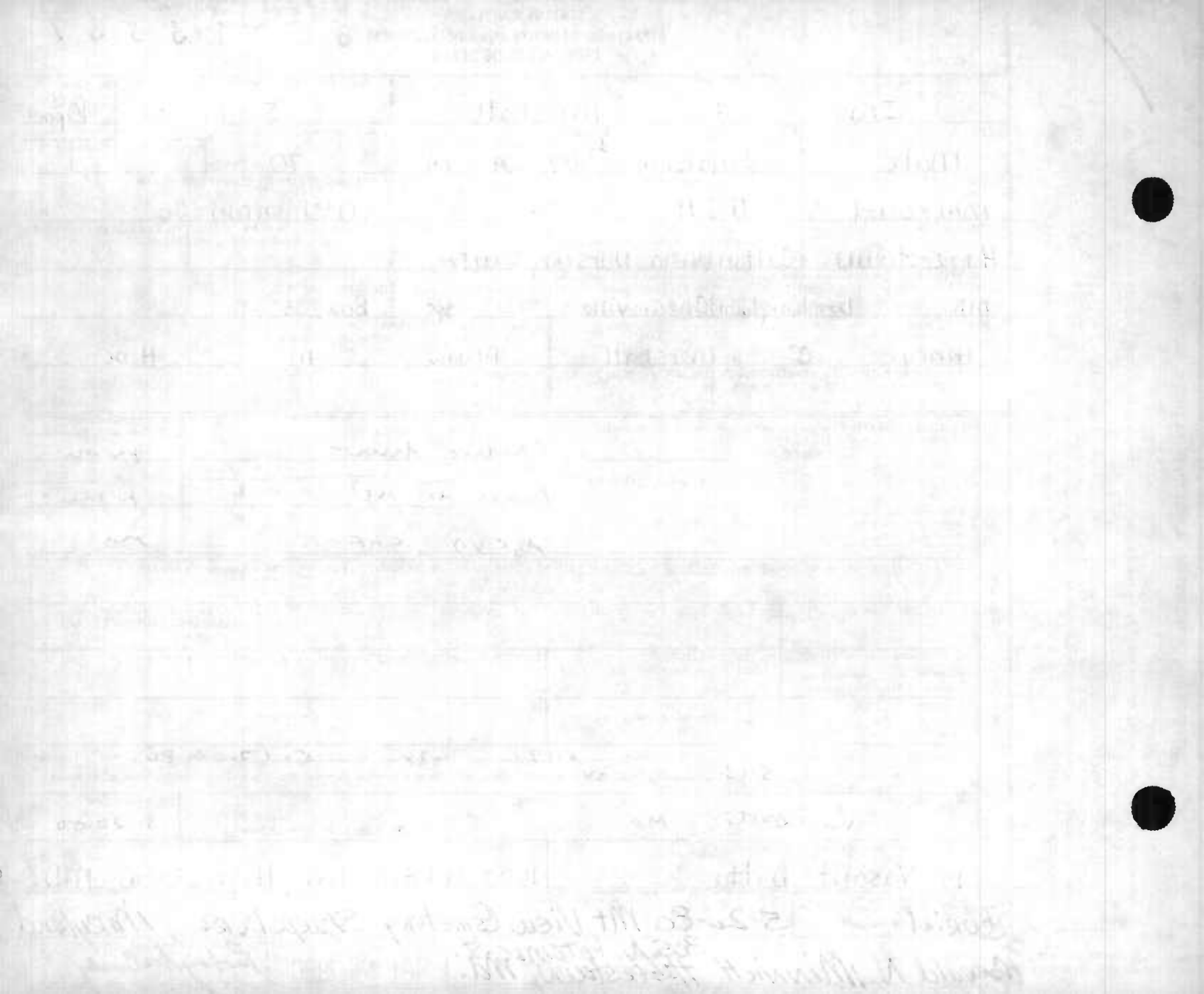


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1. STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 3 8 3 7			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <u>Ira G. Marshall</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>5-17-80</u>				2b. HOUR <u>10<sup>00</sup> PM</u>			
3. SEX <u>Male</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>07 29 09</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>70</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington Co.</u> MD.					
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Colton Villa Nursing Center</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD.</u> 13b. COUNTY <u>Washington</u> 13c. CITY OR TOWN <u>Chewsville</u>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>Box 35</u>					
14. FATHER'S NAME FIRST MIDDLE LAST <u>Henry C. Marshall</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Annie M. Hine</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410- Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Path AC MI</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ACVD, CHF</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 min</u> <u>2 hr</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-13-80</u> , 19 <u>80</u> , to <u>5-17-80</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>5-13-80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Vasant Datta MD</u>				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5-20-80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Vasant Datta</u>				22e. ADDRESS <u>1600 Oak Hill Ave Hagerstown MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>5-20-80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt View Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Sharpsburg Maryland</u>					
24. FUNERAL DIRECTOR NAME <u>Gerald N. Minnich</u>				25a. DATE REC'D. BY REGISTRAR <u>MAY 22 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					



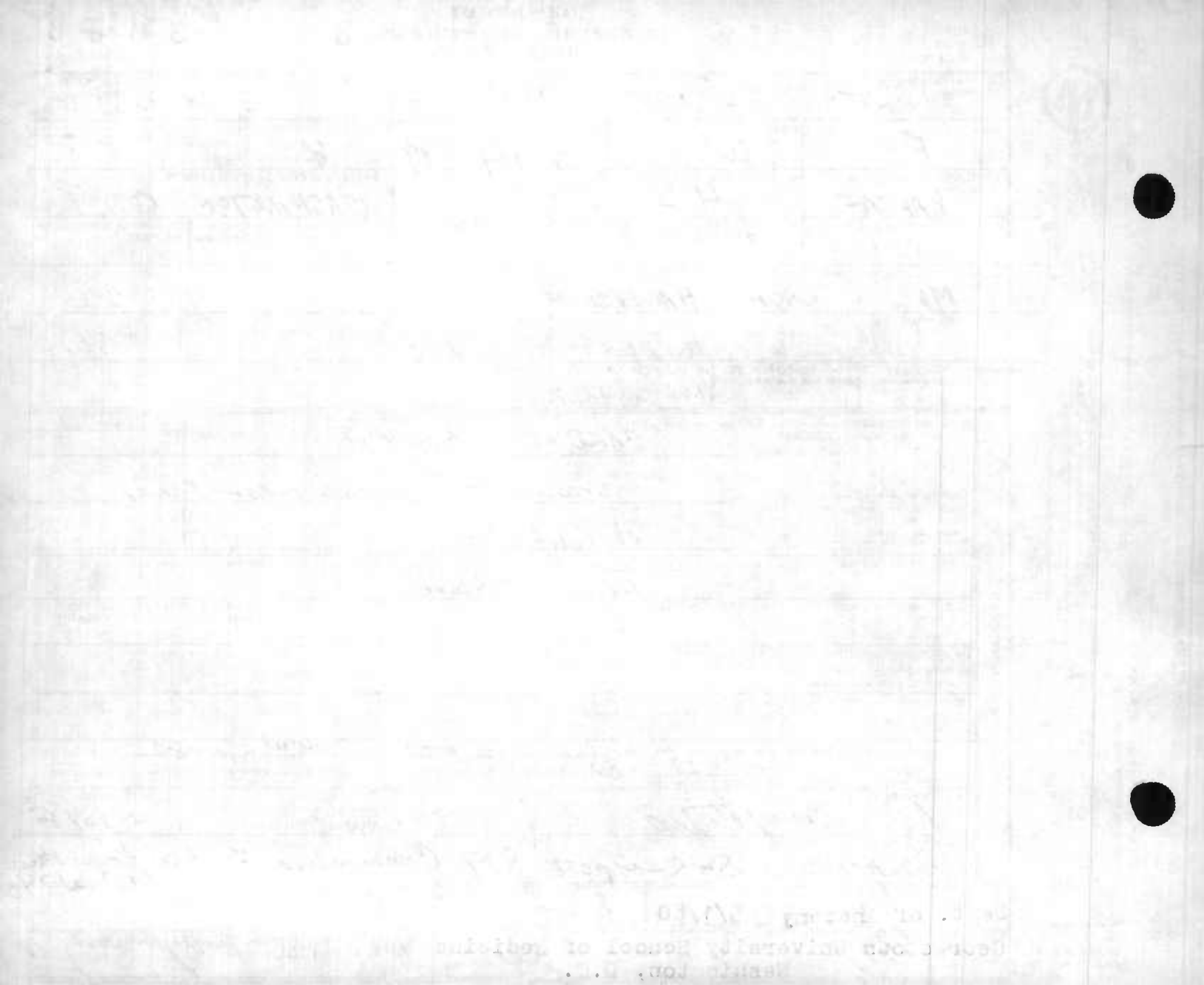
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHM-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 3 3 3 8					
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH					REG. NO.							
1 DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH DAY YEAR		2b HOUR		
RUTH ELIZABETH MARSHALL									4 28 80				1:30 PM		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
F			W			7 14 19			60			MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH						
KANSAS			U.S.						WASHINGTON CO. MD.						
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN															
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS						
MD.			WASH		HAGERSTOWN		YES <input type="checkbox"/> NO <input type="checkbox"/>		50 SUMMIT AVE						
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME												
FIRST MIDDLE LAST			FIRST MIDDLE LAST												
MARION K STEPHENS			RUTH SELL												
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS						
			466-20-1325												
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST															
2639 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Malnutrition															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Alcohol Abuse															
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY			21c HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
			HOUR A.M. MONTH DAY YEAR												
			P.M. 19												
21d INJURY OCCURRED			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK						STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from 19 79, to April 28, 19 80, that (I) (we) lost															
saw the deceased alive on April 28, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED						
ROLANDO V. SARRAMPOTE									4/30/80						
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS												
ROLANDO V. SARRAMPOTE			879 Commonwealth Ave. Hagerstown MD 21740												
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION						
Dept. of Anatomy			5/1/80						CITY OR TOWN COUNTY STATE						
24 FUNERAL DIRECTOR			25a DATE REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE									
Georgetown University School of Medicine			MAY 7 1980			[Signature]									
Washington, D.C.															

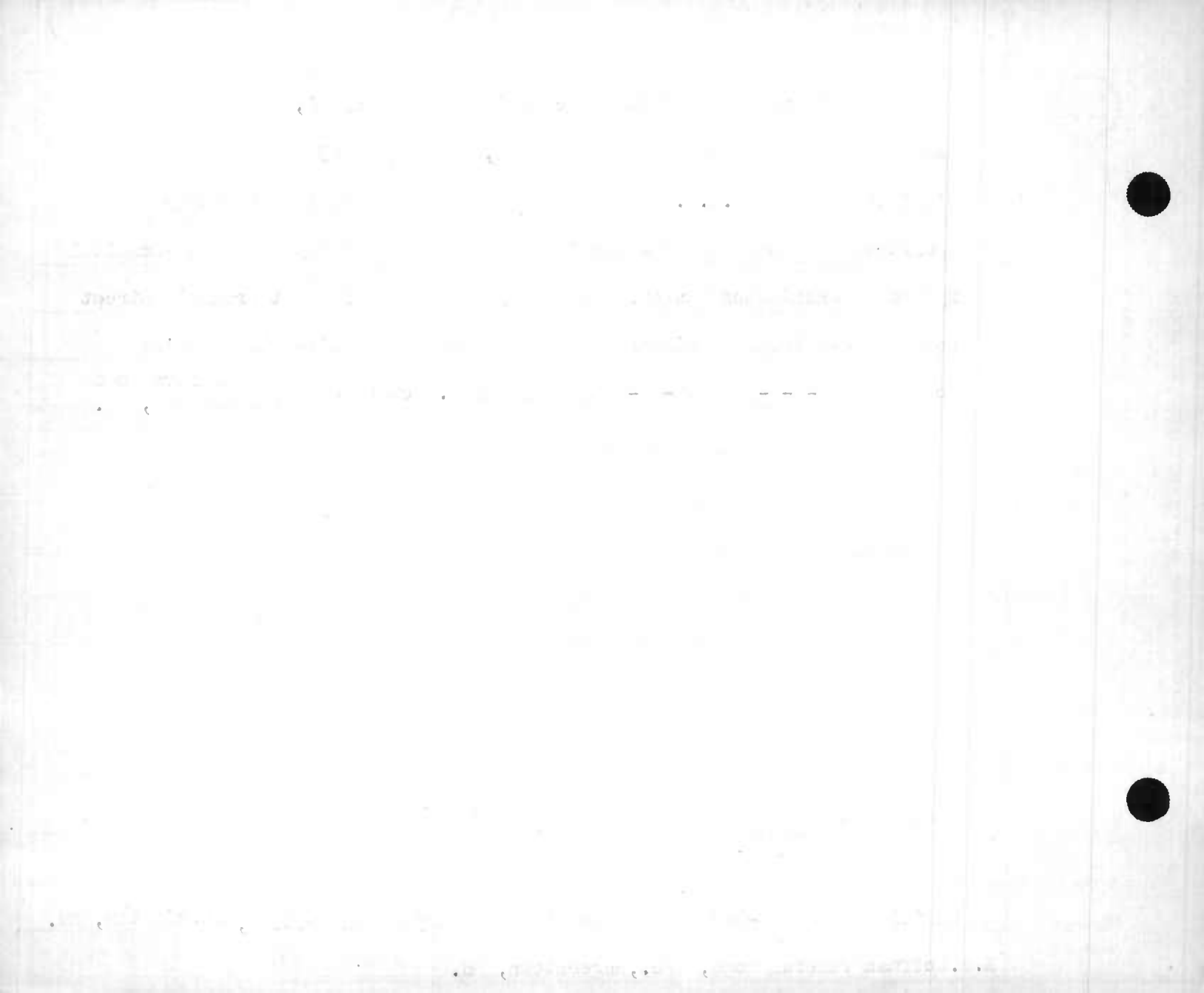


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
8 0 1 3 8 3 9									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Florence Virginia McCormick</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>May 31, 1980</b>			2b. HOUR M	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 4, 1896</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.			
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Coffman Home for the Aging</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laundry</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>116 East Franklin Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Jefferson Silman</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Elizabeth Shipe</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-18-7673</b>		17. INFORMANT ADDRESS <b>Arthur B. McCormick 106 Walgrove Road Reisterstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest.</b> 4440 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>?</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (the hospital) attended the deceased from <b>5-24</b> 19 <b>80</b> to <b>5-31</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>5-28</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Lloyd A. Hoffman</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6-2-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lloyd A. Hoffman</b>			22e. ADDRESS <b>1147 Oak Hill Ave. Hagerstown</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6-3-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Lloyd A. Hoffman</b>		



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 3 8 4 0										
1 - STATE REGISTRAR			CERTIFICATE OF DEATH								REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST			2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		
Bawn			Ellsworth		McCREA, Sr.			May 16, 1980		8:15										
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS							
Male			White			Nov. 3, 1904			75 YRS.		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH											
Michigan			U.S.A.						Washington MD.											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown			Washington County Hospital						Shipping Dept.				Army Depot							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.			Wash.			Cascade			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 1, Box 29									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME															
FIRST					MIDDLE					LAST										
Ellsworth					E. McCreA					Estella Matthews										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS										
no					219-03-0378A					Mrs. Ruth M. McCrea, Cascade, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
IMMEDIATE CAUSE (a) Renal Failure																				
1889 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Bladder.																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																				
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE						DEGREE			22c. DATE SIGNED											
Hugh J. Talton M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS														
HUGH J. TALTON						1198 Kenly Ave Hagerstown														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial			May 19 1980			Smithsburg Cemetery			Smithsburg, Wash. Md.											
24. FUNERAL DIRECTOR NAME						24b. DATE OF REGISTRATION			24c. STATE OF REGISTRATION											
Dennis L. Davis						MAY 22 1980			BALTIMORE											
Davis Funeral Home, Smithsburg, Md.																				

Reverend Father  
Carmichael Bishop

Yours truly  
John T. Brown

James A. Brown



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 3 8 4 1			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>Benjamin Washington METZ</b>				2a DATE OF DEATH MONTH DAY YEAR <b>May 29, 1980</b>		2b HOUR <b>M</b>	
3 SEX <b>male</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>May 13, 1902</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Trego, Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13b STREET ADDRESS <b>401 Pangborn Boulevard</b>	
13a STATE <b>Maryland</b>		13b COUNTY <b>Washington</b>		13c CITY OR TOWN <b>Hagerstown</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>George W. Metz</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Lizer</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W.II</b>		17 INFORMANT ADDRESS <b>Cora Kershner, 2377 Penna. Ave., Hag., Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Jaundice, Uremia, Diabetes</b>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>24 June 1976</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (XXXXXX) attended the deceased from <b>28 May 1980</b> to <b>29 May 1980</b> , that (I) (we) last saw the deceased alive on <b>28 May 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Richard T. Binford, M.D.</b>				22c DATE SIGNED <b>29 May, 1980</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard T. Binford, M.D.</b>				22e ADDRESS <b>1135 Potomac Ave. Hagerstown, MD 21740</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b DATE <b>May 31, 1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b> ADDRESS <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>				25a DATE REC'D. BY REGISTRAR <b>JUN 2 1980</b>		25b REGISTRAR'S SIGNATURE <b>Richard T. Binford</b>	

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For the purpose of the

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	1	3	8	4	2	
FOR 1- STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Nellie Marie Michael</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>May 6, 1980</b>				2b. HOUR <b>6:15 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 24, 1907</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD									
10. CITY OR TOWN OF DEATH <b>Boonsboro</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>RFD-1 Home Of Son</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>										13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Clearspring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>RFD-1</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Franklin Clopper</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Carbaugh</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>215-48-1620</b>		17. INFORMANT ADDRESS <b>Mrs. Andrew H. Michael Big Spring, Md.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiogenic Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Heart May Be Enlarged</b>										APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:43 P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>28 415 80</b>									
22a. I certify that (i) (this hospital) attended the deceased from <b>4-15-80</b> to <b>5-7-80</b> , that (i) (we) last saw the deceased alive on <b>4-15-80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death.										22b. SIGNATURE DEGREE <b>E. E. Landry</b>				22c. DATE SIGNED <b>5-7-80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. E. Landry</b>				22e. ADDRESS <b>382 John Overland, Maryland</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>May 8, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Wash. Md.</b>							
24. FUNERAL DIRECTOR <b>Donald E. Thompson</b> Thompson Funeral Home Clearspring, Md.						25a. DATE REC'D. BY REGISTRAR <b>MAY 12 1980</b>		25b. REGISTRAR'S SIGNATURE <b>W. J. Kennedy</b>									



*Charles E. Thompson*

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 3 8 4 3											
1- FOR STATE REGISTRAR				REG. NO.											
1 DECEASED NAME (TYPE OR PRINT) <b>Richard Allison Miller</b>				2a DATE OF DEATH MONTH DAY YEAR <b>May 13 1980</b>		2b HOUR <b>5:25am</b>									
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>07 29 35</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>44</b> YRS. <table border="1"><tr><td colspan="2">IF UNDER 1 YEAR</td><td colspan="2">IF UNDER 24 HRS</td></tr><tr><td>MONTHS</td><td>DAYS</td><td>HOURS</td><td>MIN</td></tr></table>		IF UNDER 1 YEAR		IF UNDER 24 HRS		MONTHS	DAYS	HOURS	MIN
IF UNDER 1 YEAR		IF UNDER 24 HRS													
MONTHS	DAYS	HOURS	MIN												
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington Co.</b> MD.									
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Co. Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Borough Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b STREET ADDRESS <b>302 W. Seventh St.</b>									
13a STATE <b>Penna.</b>		13b COUNTY <b>Franklin</b>		13c CITY OR TOWN <b>Waynesboro</b>											
14 FATHER'S NAME FIRST <b>Hiram</b> MIDDLE <b>G.</b> LAST <b>Miller</b>		15. MOTHER'S MAIDEN NAME FIRST <b>M.</b> MIDDLE <b>Elizabeth</b> LAST <b>Simcox</b>													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO <b>184-26-4820</b>		17 INFORMANT <b>Joan Miller</b>		ADDRESS <b>302 W. Seventh St. Waynesboro, Pa.</b>									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>185-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sarcoma of prostate</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that (1) the hospital attended the deceased from <b>9/20</b> , 19 <b>79</b> , to <b>5/13</b> , 19 <b>80</b> , that (1) <del>was</del> <b>was</b> last saw the deceased alive on <b>5/13</b> , 19 <b>80</b> , and that in (my) <del>last</del> <b>last</b> opinion death occurred on the date and hour and from the causes stated above. (If <del>we</del> <b>we</b> did <del>not</del> <b>not</b> view the body after death.)															
22b SIGNATURE <b>George Newman II</b> DEGREE <b>Ph.D./M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c DATE SIGNED <b>5/13/80</b>									
22a PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. George Newman II</b>				22b ADDRESS <b>1825 Howell Rd. Hagerstown, Md. 21740</b>											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>5/16/1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Waynesboro Franklin Penna.</b>									
24 FUNERAL DIRECTOR <b>David H. Dine</b>		ADDRESS <b>50 S. Broad St. Waynesboro, Pa.</b>		25 MAY REC'D BY REGISTRAR <b>MAY 19 1980</b>		25 REGISTRAR'S SIGNATURE <b>[Signature]</b>									

BP

Serial 1716/1980 Green Hill Cemetery  
Waynesboro Franklin Tenn.  
2011 Road 32  
Waynesboro, Va.

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10/13/80

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DHMH - 16 50M 1/76  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 0 1 3 8 4 4

## CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			5 - 8 - 1980			3 <sup>00</sup> A M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
male			white			2 8 1902			78 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			USA						WASHINGTON MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Garlock Memorial Home			Cab Driver					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
md.			WASH.			Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
Harry T. Morningstar			Meta Rena Glass			Unknown			213-16-0321		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebro-Vascular</u> DUE TO, OR AS A CONSEQUENCE OF <u>Ascend.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> (c) <u></u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
David S. Morningstar			1644 Timberlane Dr. Hagerstown, Md.								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/14</u> 19 <u>80</u> to <u>5/8</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4/14</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			22c. DATE SIGNED					
<u>Sidney Novenstein</u>			MD			5/8/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
SIDNEY NOVENSTEIN			FUNKSTOWN MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
Burial			5-10-80			Mt. View Cemetery			Sharpsburg, Washington, Md.		
24. FUNERAL DIRECTOR			25a. DATE			25b. BY REGISTRATION			25c. REGISTERED SIGNATURE		
NAME ADDRESS			MAY 14 1980								
A.K. Coffman Funeral Home, Inc., Hagerstown, Md.											

2318



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		2c. MIN	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		Herman Kenneth MOSER		May 4, 1980		\$:30A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		7. IF UNDER 1 YEAR	
Male		White		April 2, 1911		69		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Boonsboro, Md.		U. S. A.				Washington		Assembler	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		12c. AIRCRAFT Mfg.	
Boonsboro		Hd. 1 P. O. Box 83		Assembler					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. COUNTY		13d. CITY OR TOWN		13e. STREET ADDRESS	
Maryland		Washington		Boonsboro		Hd. 1		B. O. Box 83	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT	
Henry C. Moser		Emma Martz		No		217-10-3007		Mrs. Isabel F. Moser, P. O. Box 83	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a):		18b. SOCIAL SECURITY NO		18c. CITY OR TOWN		18d. COUNTY		18e. STATE	
4/40 Cardiac arrest (found dead in bed)		217-10-3007		Boonsboro		Md.		21713	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		18b. SOCIAL SECURITY NO		18c. CITY OR TOWN		18d. COUNTY		18e. STATE	
DU TO, OR AS A CONSEQUENCE OF (b):		18b. SOCIAL SECURITY NO		18c. CITY OR TOWN		18d. COUNTY		18e. STATE	
Arteriosclerotic heart disease		217-10-3007		Boonsboro		Md.		21713	
DU TO, OR AS A CONSEQUENCE OF (c):		18b. SOCIAL SECURITY NO		18c. CITY OR TOWN		18d. COUNTY		18e. STATE	
		217-10-3007		Boonsboro		Md.		21713	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		18b. SOCIAL SECURITY NO		18c. CITY OR TOWN		18d. COUNTY		18e. STATE	
Chronic obstructive lung disease Abdominal aortic aneurysm		217-10-3007		Boonsboro		Md.		21713	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. PLACE OF INJURY		21e. LOCATION	
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2		AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
21f. INJURY OCCURRED		21g. PLACE OF INJURY		21h. LOCATION		21i. LOCATION		21j. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
4/12 19 80 to 4/17 19 80, that (I) (we) lost		John H. Hornbaker M.D.		5-6-80		John H. Hornbaker, M.D.		645 East First St., Hagerstown, Md. 21740	
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS		22h. DATE REC'D. BY REGISTRAR		22i. REGISTRAR'S SIGNATURE		22j. REGISTRAR'S SIGNATURE	
John H. Hornbaker, M.D.		645 East First St., Hagerstown, Md. 21740		MAY 8 1980		John H. Hornbaker		John H. Hornbaker	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. LOCATION	
Burial		5-7-80		Boonsboro Cemetery		Boonsboro, Wash. Co., Md.		Boonsboro, Wash. Co., Md.	
24. FUNERAL DIRECTOR		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION		24e. LOCATION	
John H. Bast, Jr.		5-7-80		Boonsboro Cemetery		Boonsboro, Wash. Co., Md.		Boonsboro, Wash. Co., Md.	

04/12/2012

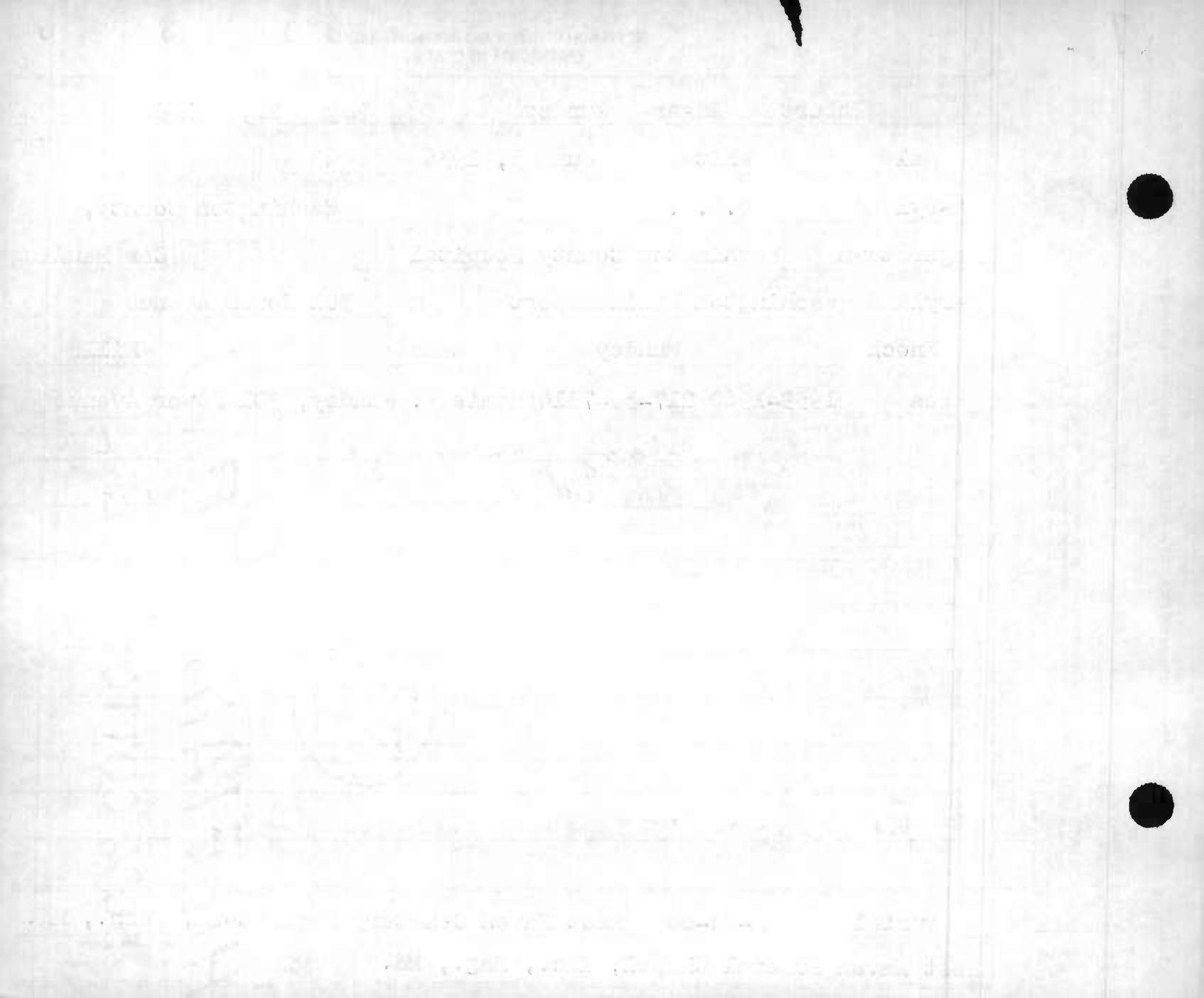
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 3 8 4 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Edgar Munday				2a. DATE OF DEATH MONTH DAY YEAR May 22, 1980		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 3, 1936		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Car Hauling		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Williamsport	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 301 Bower Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Enoch Munday				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Mills			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1959-1960		17. INFORMANT ADDRESS Mamie V. Munday, 301 Bower Avenue			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <i>pulmonary hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>cat cut Coroner</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>1 yr</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J. C. E. L. H. M.</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-24-80		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Md.	
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag.,				25a. DATE REC'D. BY REGISTRAR MAY 27 1980		25b. REGISTRAR'S SIGNATURE <i>Raymond M. Munday</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMM-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 8013847									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Grace		La		fawn		Myers		8-25-80		8:25 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Female		White		6-26-1903		76		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Washington				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Washington County Hospital		Homemaker		Home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Washington		Hancock		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		70 E. Main Street			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
William		Sarah		Gertrude		Souders					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		213 74 1428		Ruth I. Myers		same as 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>										years.	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb.</u> 19 <u>1977</u> to <u>May</u> 19 <u>1980</u> , that (I) (we) lost saw the deceased alive on <u>May</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Gloria F. Pura</u> DEGREE <u>MD</u>		22c. DATE SIGNED <u>5/25/80</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
GLORIA F. PURA		382 S. Cleveland		Augustova							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		5-28-80		Tonoloway Baptist		Fulton Penna.					
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Richard D. Shaw		Hancock MD.		JUN 2 1980							

BP

1-3-4-5  
1-2-3-4-5  
1-2-3-4-5

*[Faint, illegible handwriting on lined paper]*

*[Faint, illegible handwriting at the bottom of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		8 0 1 3 8 4 8		REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>Irene May NEEDY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 4, 1980</b>			2b. HOUR <b>9:20A M</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 11, 1884</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>95</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Trego, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.				
10. CITY OR TOWN OF DEATH <b>Boonsboro</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fahrney- Keedy Mem. Home</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Boonsboro</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>206 N. Main St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George C. Norris</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Eleanor Gloss</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>216-09-0080B</b>		17. INFORMANT ADDRESS <b>Pauline N. Needy, 8708 Colesville, Rd. Silver Spring, Md. 20910</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF AND (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>MANY YEARS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 - 14 DAYS</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 24</b> 19 <b>77</b> to <b>MAY 1</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>MAY 1</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22a. SIGNATURE <i>Edward W. Ditto III</i>				DEGREE <b>MD</b>		22b. DATE SIGNED <b>MAY 6, 1980</b>				
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>				22d. ADDRESS <b>217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-8-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Boonsboro, Wash. Co., Md.</b>				
24. FUNERAL DIRECTOR NAME <b>John H. Bast, Jr.</b>				ADDRESS <b>Boonsboro, Md. 21713</b>		25. DATE REC'D. BY REGISTRAR <b>MAY 12 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Pauline N. Needy</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 707-1234.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 0 1 3 8 4 9 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Lucy May Negley					2a. DATE OF DEATH MONTH DAY YEAR May 4, 1980			2b. HOUR M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR October 19, 1892		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Coffman Home for the Aging			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13e. STREET ADDRESS 124 Randolph Avenue			
14 FATHER'S NAME FIRST MIDDLE LAST Samuel Negley					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Elizabeth Strock				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17 INFORMANT Bertha M. Bergum		ADDRESS 124 Randolph Avenue Hagerstown, Md. 21740			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Congestive Heart Failure 4 days DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease 2 yrs. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cerebral Thrombosis - old									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-9 19 78 to 5-4 19 80, that (I) last saw the deceased alive on 5-2-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lloyd A. Hoffman				DEGREE M.D. ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-6-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lloyd A. Hoffman M.D.				22e. ADDRESS 1147 Oak Hill Ave, Hagerstown, Md. 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-7-80		23c. NAME OF CEMETERY OR CREMATORY Broadfording Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Broadfording, Washington, Md.			
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md.				25a. DATE REC'D. BY REGISTRAR MAY 9 1980					



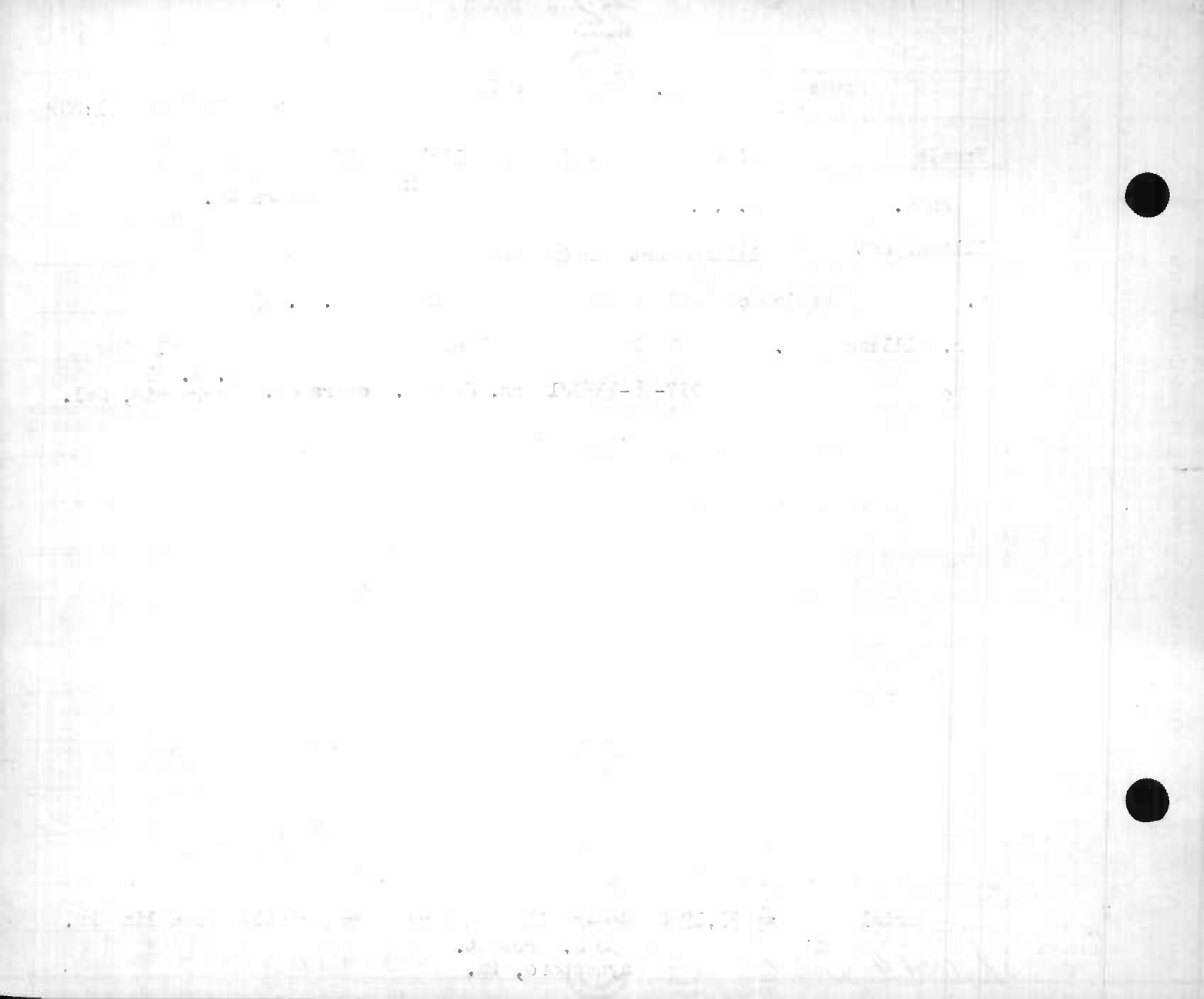
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8013850	
1. FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)		FIRST MAUDE MIDDLE EVA LAST NOBLE MAUDE EVA NOBLE				2a DATE OF DEATH MONTH DAY YEAR May 29 1980		2b HOUR 1:20P M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR July 6 1884		6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		7 UNDER 1 YEAR MONTHS DAYS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington Co.		MD.			
10 CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Williamsport Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE Md.		13b COUNTY Washington		13c CITY OR TOWN Smithsburg		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS R. D. #3			
14 FATHER'S NAME FIRST Dr. William MIDDLE P. LAST Noble					15 MOTHER'S MAIDEN NAME FIRST Alice MIDDLE LAST Fleming						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 217-58-3353J1		17 INFORMANT ADDRESS R. D. #2 Mrs. John D. Rogers Jr. Hockessin, Del.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> 0389 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>7/76</u> , 19 <u>76</u> , to <u>5-29</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5-29</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. N (we) (I) (did not) view the body after death.											
22b SIGNATURE John R. Melnick		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 5-29-80			
22d PHYSICIAN'S NAME (TYPE OR PRINT) John R. Melnick, M.D.				22e ADDRESS 16220 Frederick Rd. Gaithersburg, MD 20760							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE May 31, 1980		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Greencastle Franklin Pa.					
24 FUNERAL DIRECTOR NAME David Y. Grove		ADDRESS 50 S. Broad St. Waynesboro, Pa.		25a DATE REC'D. BY REGISTRAR JUN 3 1980		25b REGISTRAR'S SIGNATURE [Signature]					

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 3 8 5 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Belva Vivian Pyseil			2a. DATE OF DEATH MONTH DAY YEAR May 16, 1980		2b. HOUR 12 45 PM
3. SEX F	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 3 15 1923	6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waitress	12b. KIND OF BUSINESS OR INDUSTRY restaurant	
13a. STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 41 1/2 S. Potomac Street	
14. FATHER'S NAME FIRST MIDDLE LAST William H. Watson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie E. Renner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-20-2230	17. INFORMANT ADDRESS Darlene Harp, 1064-6 Noland Dr., Hagerstown,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abscission of lungs with</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>under strain to brain</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>probable infection</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>probable infection</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-14-1980</u> to <u>5-16-1980</u> , that (I) <del>was</del> lost saw the deceased alive on <u>5-16-1980</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) (did not) view the body after death.					
27b. SIGNATURE <u>Joseph S. Comdari</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED <u>5-16-80</u>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH S. COMDARI		27e. ADDRESS BOONSBORO 21713 -			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE May 19, 1980	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR MAY 21 1980	25b. REGISTRAR'S SIGNATURE <u>Robert A. Brady</u>		

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 3 8 5 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Henry Philip Recher			2a. DATE OF DEATH MONTH DAY YEAR 5-15-80		2b. HOUR 6:25 P M
3 SEX male	4 RACE Caucasion	5 DATE OF BIRTH MONTH DAY YEAR 1 3 1898	6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hagerstown	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.		
10. CITY OR TOWN OF DEATH Boonsboro	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fahrney-Keedy Mem. Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) hardware		12b. KIND OF BUSINESS OR INDUSTRY Hardware
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 412 N. Potomac St.
14 FATHER'S NAME FIRST MIDDLE LAST Harry Kieffer Recher			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Edith Geiger		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) unknown	17. INFORMANT ADDRESS Fahrney-Keedy Home, Boonsboro, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EPICERMOID CARCINOMA OF THYROID WITH METASTASIS 193- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <del>XXXXXX</del> attended the deceased from Nov. 25, 19 79, to May 15, 19 80, that (I) <del>XX</del> last saw the deceased alive on May 15, 19 80, and that in (my) <del>XX</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>XX</del> (did not) view the body after death.					
22b. SIGNATURE Edward W. Ditto, III, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED MAY 16, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-17-80	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md.	
24 FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR MAY 19 1980		25b. REGISTRAR'S SIGNATURE Morty McCreedy	





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13853					
1- FOR STATE REGISTRAR															
1 DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR				
Kathleen Laverne RINGER									ESTIMATED <input checked="" type="checkbox"/> MAY 12 19 80		6:00 PM				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			
female		white		MONTH DAY 1931		LAST BIRTHDAY 47 YRS.		MONTHS DAYS		HOURS MIN		MAY 13 19 80 11:45 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland			USA						Washington MD						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			217 W. Washington Street												
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		217 W. Washington Street							
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME										
FIRST MIDDLE LAST					FIRST MIDDLE LAST										
Melvin C. Clark					Mabel L. Holland										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS					
No					220-28-7856					Mrs. Betty Munson, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <u>E 950 - DRUG OVERDOSE</u>										EST. 2 HRS.					
9505 } CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c) DUE TO, OR AS A CONSEQUENCE OF															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				4:00 PM MAY 12 19 80				SELF INFLICTED OVERDOSE DRUGS & ALCOHOL							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
				HOME				217 WEST WASHINGTON ST., HAGERSTOWN, WASH., MD.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
<i>Edward W. Ditto</i>				M.D. DEPUTY MEDICAL EXAMINER				MAY 14, 1980							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
EDWARD W. DITTO, III, M.D.				HAGERSTOWN, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
burial				May 14, 1980		Rose Hill Cemetery				Hagerstown, Wash., Maryland					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
MINNICH FUNERAL HOME						MAY 19 1980		<i>Robert McCreedy</i>							
NAME ADDRESS															
415 E. Wilson Blvd., Hagerstown, Md. 21740															



24

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

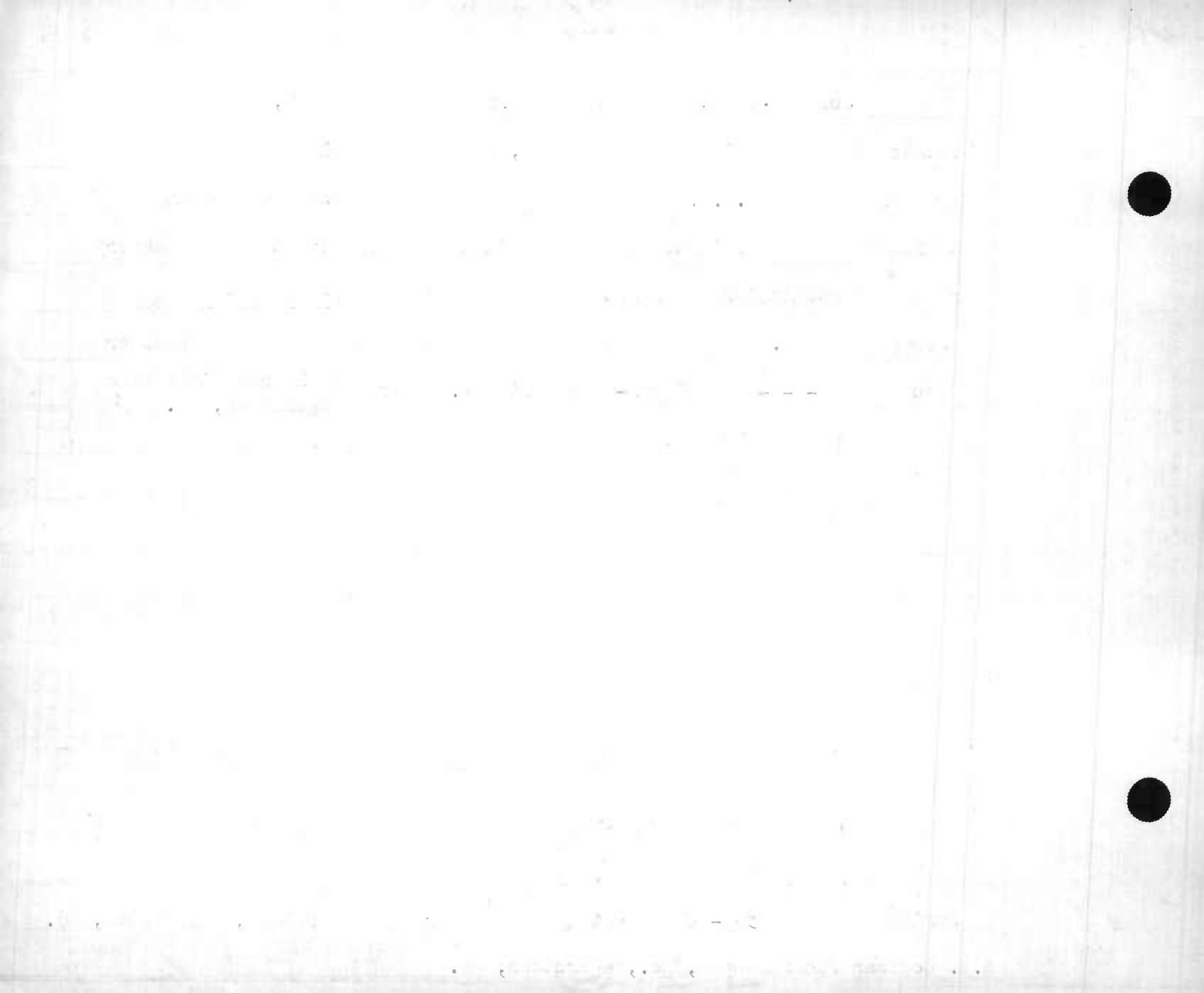
1 3 8 5 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Josephine Adams Rosenberger</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 7, 1980</b>			2b. HOUR M <b>AM</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 28, 1888</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>President</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2001 Greenfield Road</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Joseph L. Adams</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Henrietta Buesner</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220-28-9014</b>		17 INFORMANT <b>Alice A. Paxton</b>		ADDRESS <b>2001 Greenfield Road Hagerstown, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of colon with metastases</b> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) <del>the hospital</del> attended the deceased from <b>May 7</b> , 19 <b>80</b> , to <b>May 7</b> , 19 <b>80</b> , that (1) <del>the</del> last saw the deceased alive on <b>May 6</b> , 19 <b>80</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (2) <del>the</del> I did not view the body after death.										
22b. SIGNATURE <b>Charles E. Spencer M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5-9-80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles E. Spencer</b>						22e. ADDRESS <b>1198 Kenly Ave Hagerstown Md</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5-9-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, Md.</b>			
24 FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>						ADDRESS <b>1198 Kenly Ave Hagerstown Md</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 14 1980</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (1))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3013855	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN WILLIAM ROWE</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>MAY 1 1980</b>			2b. HOUR <b>10:30 A.M.</b>		
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 11, 1930</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>49 YRS.</b>		IF UNDER 24 YRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>MAY 1 1980</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington Co.</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Co. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farm Work</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	
13a. STATE <b>PENNA.</b>				13b. COUNTY <b>Franklin</b>		13c. CITY OR TOWN <b>Greencastle</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>R.D. # 2</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John D. Rowe</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Pyle</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. <b>Korean Conflict 177-24-5334</b>		17. INFORMANT ADDRESS <b>Betty Rowe, R.D. # 2 Greencastle, Pa</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>#429 - ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 - 10 YEARS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Edward W. Ditto</b>						TITLE (SPECIFY) <b>DEPUTY</b>		MEDICAL EXAMINER <b>217 WEST WASHINGTON STREET</b>		DATE SIGNED <b>MAY 2, 1980</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>						ADDRESS <b>HAGERSTOWN, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>5/4/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Macedonia Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Antrim Twp Franklin Penna.</b>			
24. FUNERAL DIRECTOR NAME <b>Hawel M. Zimmerman</b>						ADDRESS <b>Greencastle, Pa</b>		25a. DATE FILED BY REGISTRAR <b>MAY 7 1980</b>		25b. REGISTRAR'S SIGNATURE <b>W. J. McCready</b>	

10:00

11:00

12:00

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6:00

7:00

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11:00

12:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>ROBERT JOSEPH SANDERS</b>			2a. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>80</b>			2b. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>March 30, 1904</b>		6. AGE (In years lost birthday) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington County</b> Md.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>608 George Street</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Truck Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>608 George Street</b>	
14. FATHER'S NAME First Middle Last <b>James H. Sanders</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Louise Keibel</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>214-09-5489</b>		17. INFORMANT <b>James R. Sanders</b>		18. CORONER'S ADDRESS <b>18 Cornwall Road New Castle, Delaware</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>marked undersentinel</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Alcoholism, Cancer of prostate, Emphysema, ASCVD.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) ( <del>we</del> ) attended the deceased from <b>26 April</b> , 19 <b>74</b> , to date <b>26 April</b> , 19 <b>80</b> , that (I) ( <del>we</del> ) lost saw the deceased alive on <b>6 March</b> , 19 <b>80</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) did (did not) view the body after death.									
22b. SIGNATURE <b>Richard T. Binford, M.D.</b>				22c. DATE SIGNED <b>21 May, 1980</b>		22d. ADDRESS <b>1135 Potomac Avenue, Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-22-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Washington, Md.</b>			
24. FUNERAL DIRECTOR <b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>				25. REC'D BY REGISTRAR <b>MAY 27 1980</b>		25b. REGISTRAR'S SIGNATURE			



DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
STATE OF NEW YORK

DATE OF BIRTH: 1900-01-01

PLACE OF BIRTH: NEW YORK

DATE OF DEATH: 1900-01-01

PLACE OF DEATH: NEW YORK

CAUSE OF DEATH: DISEASE

DATE OF BURIAL: 1900-01-01

PLACE OF BURIAL: NEW YORK

NAME OF DECEASED: [illegible]

AGE AT DEATH: [illegible]

SEX: [illegible]

RELATIONSHIP: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

DATE OF INTERVIEW: [illegible]

INTERVIEWER: [illegible]

DATE OF REPORT: [illegible]

REPORTER: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph Enniss SCHALLER			May 11, 1980		6:30 A M	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Oct. 3, 1906	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 15 Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10 CITY OR TOWN OF DEATH 90 Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ravenwood Lutheran Village		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer	12b. KIND OF BUSINESS OR INDUSTRY Tool Co.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. CITY OR TOWN Wash.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS Rt. 2, Box 8	
14 FATHER'S NAME FIRST MIDDLE LAST Ulysses G. Schaller			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie M. Harbaugh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - 173-03-0837		17 INFORMANT ADDRESS Mrs. Doris E. Richardson, Hagerstown, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month
4292 } DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD						5 years
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Dec. 15, 19 54, to May 11, 19 80, that (I) (we) lost saw the deceased alive on May 6, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE Charles F. Hess M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-12-80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. Hess, M.D.				22e. ADDRESS P.O. Box 248, Smithsburg, MD 21783		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 11, 1980	23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg Wash. Md.	
24 FUNERAL DIRECTOR NAME Davis Funeral Home, Smithsburg, Md., 21783				25. DATE REC'D BY REGISTRAR MAY 19 1980		

Charles E. Henn, M.D.  
P.O. Box 248, Smithsburg, MD 21759

Charles E. Henn, M.D.

May 6 1980

May 11 1980

8-13-80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 3 8 5 8			
1. FOR STATE REGISTRAR		REG. NO.											
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Evelyn LaRue SEIBERT								May 12, 1980					4:03 P. M.
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. UNDER 1 YEAR		7b. UNDER 24 HRS			
female		white		June 2, 1919		60 YRS		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Washington							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Washington County Hospital		housewife									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		282 S. Potomac St.					
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME											
Charles H. Goetz		Anna Drury											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS							
		214-09-4267		Paul Seibert, Hagerstown, Md.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u> 5712 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CIRRHOSIS LIVER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC ALCOHOLISM</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HOURS YEARS MANY YEARS													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>INTERSTITIAL PNEUMONIA</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) <del>XXX</del> hospital) attended the deceased from <u>MAY 9</u> , 19 <u>80</u> , to <u>MAY 12</u> , 19 <u>80</u> , that (I) <del>(XX)</del> last saw the deceased alive on <u>MAY 12</u> , 19 <u>80</u> , and that in (my) <del>(XXX)</del> opinion death occurred on the date and hour and from the causes stated above (I) <del>(XXX)</del> (did not) view the body after death.		22b. SIGNATURE <u>Edward W. Ditto, III, M.D.</u>		22c. DATE SIGNED MAY 13, 1980									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
EDWARD W. DITTO, III, M.D.		217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
burial		May 14, 1980		Rose Hill Cemetery		Hagerstown, Wash., Maryland							
24 FUNERAL DIRECTOR		24b. NAME		24c. ADDRESS		24d. DATE REC'D. BY REGISTRAR		24e. REGISTRAR'S SIGNATURE					
MINNICH FUNERAL HOME		415 E. Wilson Blvd., Hagerstown, Md. 21740				MAY 16 1980		<u>Robert McCreedy</u>					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 3 8 5 9	
1 - FOR STATE REGISTRAR			CERTIFICATE OF DEATH								
1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			MONTH DAY YEAR			2b HOUR		
Alice Mae SHAFER			May 10, 1980						M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR		7 UNDER 24 HRS	
Female		White		Sept. 27, 1894		85		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Washington MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Avalon Manor				Salesperson		Retail			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		163 South Potomac Street			
14 FATHER'S NAME						15 MOTHER'S MAIDEN NAME					
George Walter Drill						Mary Anne StClair					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
no				214-09-4706		Mr. Dennis Shafe, Hagerstown, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u> <u>4409</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>GENERALIZED ARTERIO-SCLEROSIS WITH</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>CIRCULATORY INSUFFICIENCY</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>CHRONIC BRAIN SYNDROME SENILITY</u>											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>3/26</u> 19 <u>80</u> , to <u>5/10</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4/23</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b SIGNATURE <u>[Signature]</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <u>5/12/80</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>R. AMARILLO</u>				22e ADDRESS <u>127 KING ST. HAGERSTOWN MD</u>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b DATE <u>May 13, 1980</u>		23c NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>			23d LOCATION Hagerstown, Wash., Maryland		
24 FUNERAL DIRECTOR NAME <u>MINNICH FUNERAL HOME</u> ADDRESS <u>415 E. Wilson Blvd., Hagerstown, Maryland 21740</u>						25a DATE REC'D. BY REGISTRAR <u>MAY 16 1980</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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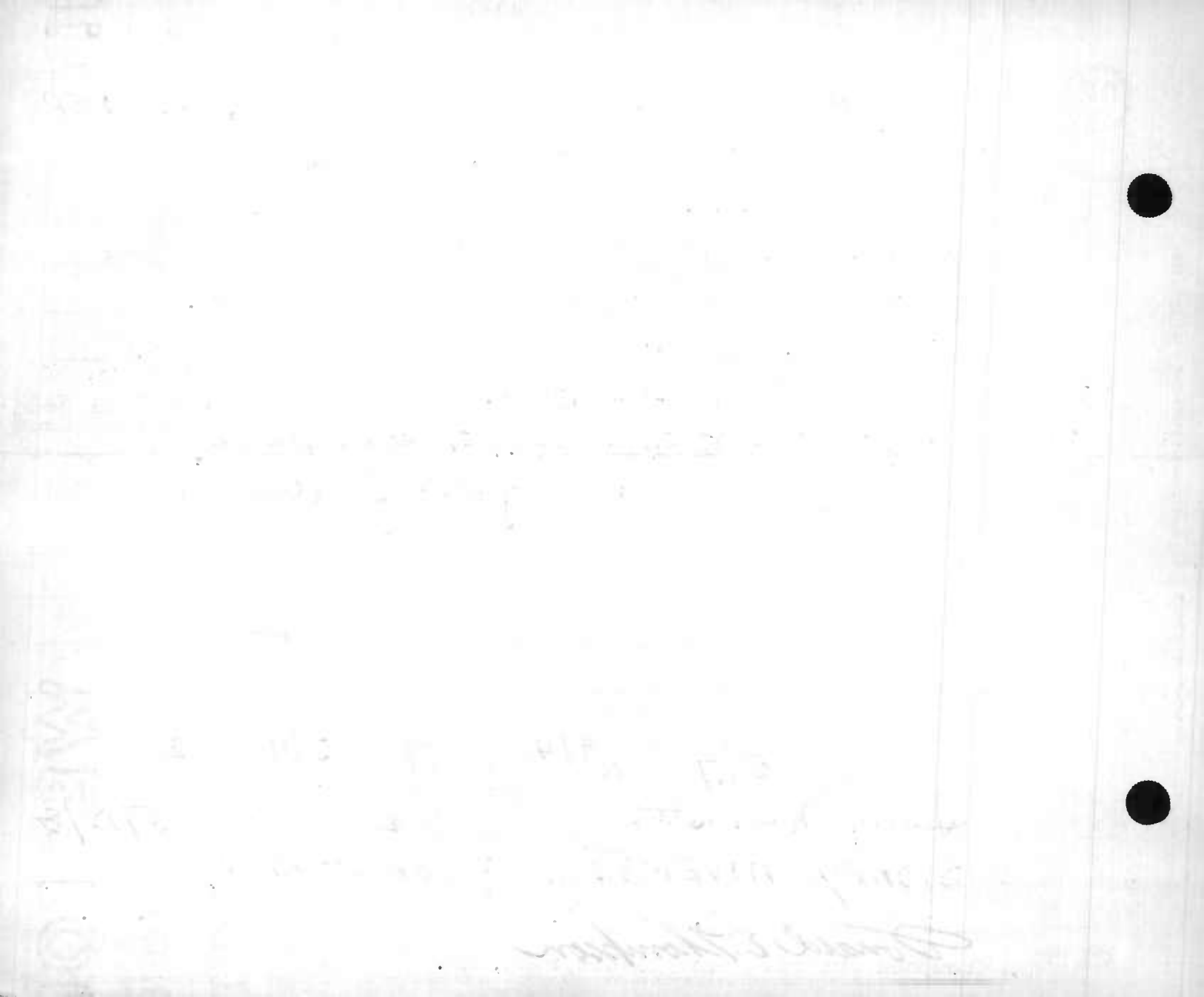
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 3 8 6 0  
CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) Hattie Hillyer Shirk		2a DATE OF DEATH MONTH DAY YEAR May 11, 1980	
3 SEX Female		2b HOUR 2:35 P.M.	
4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR April 15, 1888	
6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	
7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		10 CITY OR TOWN OF DEATH Hagerstown	
11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b KIND OF BUSINESS OR INDUSTRY Home		13a STATE Maryland	
13b COUNTY Washington		13c CITY OR TOWN Hagerstown	
14 FATHER'S NAME FIRST MIDDLE LAST Edwin B. Rash		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Irwin	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 214-34-1073	
17 INFORMANT Mrs. Laura Hull		ADDRESS Hagerstown, Md. 106 Greenmount Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart disease</u> 4/140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>9/14</u> , 19 <u>79</u> , to <u>5/11</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>5/7</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE <u>James Nowater</u>		22c DATE SIGNED 5/12/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) S. DREY ROVENSTEIN		22e ADDRESS FUNKSTOWN MD.	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE May 13, 1980	
23c NAME OF CEMETERY OR CREMATORY St. Pauls		23d LOCATION City or Town County STATE Clearspring Wash. Md.	
24 FUNERAL DIRECTOR Donald E. Thompson		25a DATE REV'D BY REGISTRAR MAY 13 1980	
25b REGISTRAR'S SIGNATURE Betsy McCready		25c REGISTRAR'S NAME Betsy McCready	





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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>HELEN MAE SHUPP</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 21, 1980</b>			2b. HOUR <b>9:15 A M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 17, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County, MD</b>			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Washington</b> 13c. CITY OR TOWN <b>Hagerstown</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2020 Gay Street</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clayton C. Shupp</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nora E. Mowen</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>215-36-6019</b>		17. INFORMANT ADDRESS <b>John Kenneth Shupp, 2020 Gay Street</b>					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPSIS</b> <b>2001</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>GRANULOCYTOPENIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHEMOTHERAPY</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>? 1 WEEK</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>LYMPHOSARCOMA, POORLY DIFFERENTIATED, LYMPHOCYTIC TYPE</b>									
19a. DATE OF OPERATION <b>1971</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>STAGING OF LYMPHOMA</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>MAY 20</b> , 19 <b>80</b> , to <b>MAY 21</b> , 19 <b>80</b> , that (1) (we) last saw the deceased alive on <b>MAY 21</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b> MD					22c. DATE SIGNED <b>5-21-80</b>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARRY M. COHEN, MD</b>					22f. ADDRESS <b>1198 KENLY AVE HAGERSTOWN, MD, 21740</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-23-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery Hagerstown, Wash., Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Rest Haven Funeral Chapel, Inc., Hag., Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 27 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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STAFF/STUDENT/ALUMNI/ALUMNA/ALUMNIUS/ALUMNAE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 3 8 6 2			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) EDITH ZETA Smith				2a DATE OF DEATH MONTH DAY YEAR 5 8 80		2b HOUR 4:55 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 9 4 00		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn. A.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a STATE MD				13b COUNTY Washington		13c CITY OR TOWN Clear Spring	
14 FATHER'S NAME FIRST MIDDLE LAST Barnabas Nove Keefer				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA Belle Weiler			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO 219-20-0610		17 INFORMANT Rosalie J. Thomson Item #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cerebral Vascular Accident</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Severe Hypertension in</u> <u>2 Congestive HT Failure</u> <u>3 Ulethostatic Cause</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 1000 AM			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 5 8 19 80 to 5 8 19 80, that (I) (we) lost saw the deceased alive on 5 8 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b SIGNATURE Mary E. Money MD				DEGREE MD		22c DATE SIGNED 5.9.80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MARY E. MONEY MD				22e ADDRESS 1198 Kenly Ave Hagerstown MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE May 11, 1980		23c NAME OF CEMETERY OR CREMATORY Shank Town Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Clear Spring Washington MD	
24 FUNERAL DIRECTOR NAME MAJOR M. Osborne P.O. Box 348 Wm. A. Md				25 DATE RECEIVED BY REGISTRAR MAY 6 1980		26 REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, and should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 3 8 6 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN KENNETH SMITH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5-28-80</b>			2b. HOUR <b>7:28 PM</b>			
3. SEX <b>m</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-16-39</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>41</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>11</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON CT.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Crane</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b>			13c. COUNTY <b>Washington</b>		13d. CITY OR TOWN <b>Clearspring</b>		13e. STREET ADDRESS <b>RFD-2</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Smith</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Jane Lieb</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO <b>182-32-4758</b>		17. INFORMANT ADDRESS <b>Mrs. Nancy Smith RFD-2 Clearspring</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> 2720 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>acute myocardial infarction</b> (c) <b>Hypercholesterolemia</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b> <b>20 min</b> <b>10 yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5-28-1980</b> , to <b>1980</b> , the (I) (we) last saw the deceased alive on <b>5-28-1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>W. Joseph M.D.</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>5-29-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM L. JOSEPH, M.D.</b>						22e. ADDRESS <b>WASHINGTON COUNTY HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>			23b. DATE <b>May 31, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clearspring, Wash. Md.</b>		
24. FUNERAL DIRECTOR <b>Emmanuel E. Thompson</b> Thompson Funeral Home Clearspring, Md.						25a. DATE REC'D. BY REGISTRAR <b>JUN 3 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony M. ...</b>	

MEDICAL CERTIFICATION



2-1860

THE END

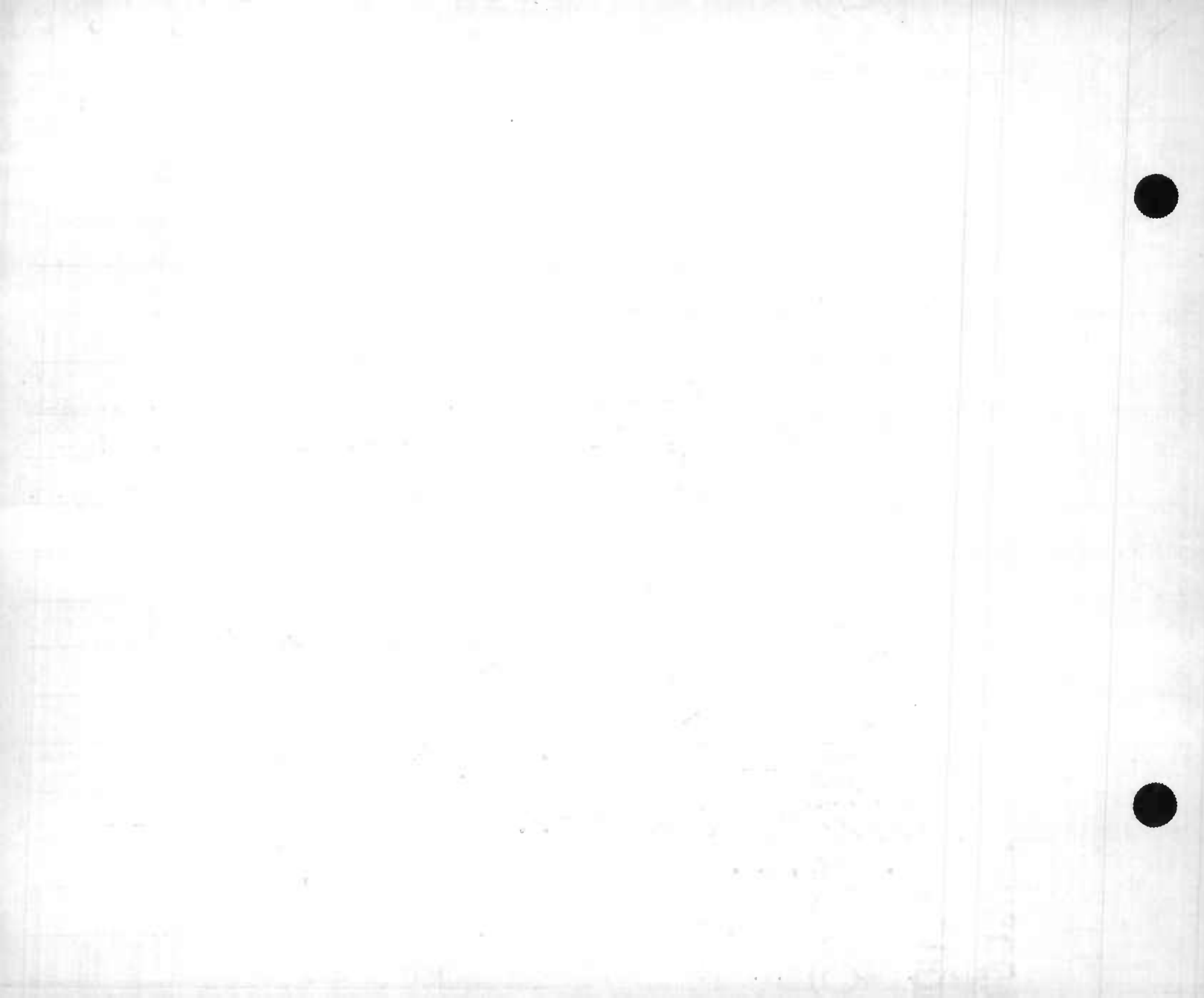
Wm. B. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 3 3 6 4	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Bertha Mary STAVROS</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>May 1 1980</i>		2b. HOUR <i>10:28 P M</i>
3 SEX <i>Female</i>	4 RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Aug 30 1904</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>76</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>France</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>WASHINGTON</i> MD.	
10 CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Baker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Bakery</i>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Williamsport</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>201-07-6746</i>		17 INFORMANT ADDRESS <i>Md. Mary E. Karavias 308 Dellwyn Dr. Hagerstown</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>410-</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>&lt; 1 hr</i> <i>15 + yrs</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>none</i>					
19a. DATE OF OPERATION <i>Sept 59</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>none</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>none</i>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>none</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>none</i>	
22a. I certify that (I) (the <del>physician</del> ) attended the deceased from <i>Sept. 59</i> , to <i>May 1 80</i> , that (I) (we) last saw the deceased alive on <i>4-7-</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Max E. Byrkit</i>				22c. DATE SIGNED <i>5-2-80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Max E. Byrkit, M.D.</i>				22e. ADDRESS <i>28 West Potomac Street Williamsport, Maryland 21795</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>May 4, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenlawn Mem. Park</i>	
23d. LOCATION CITY OR TOWN <i>Williamsport</i>		23e. COUNTY <i>Washington</i>		23f. STATE <i>Md.</i>	
24 FUNERAL DIRECTOR NAME <i>Major M. Osborne</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 22 1980</i>	
ADDRESS <i>P.O. Box 348 Williamsport Md</i>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	





FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST Merrill F Kenner Stevens						2a. DATE KNOWN OF DEATH				ESTIMATED May 29 80		MONTH DAY YEAR					
3. SEX male		4. RACE Cauc.		5. DATE OF BIRTH Nov 9 1998		6. AGE (IN YEARS) 81		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		8. DATE PRONOUNCED DEAD May 29 80				MONTH DAY YEAR		2d. HOUR 7:30							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Washington County											
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Hospital Center								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman				12b. KIND OF BUSINESS OR INDUSTRY Automobile							
13a. STATE Md.						13b. COUNTY Carroll				13c. CITY OR TOWN Westminster				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 412 Baldwin Park Dr. Apt. A1							
14. FATHER'S NAME FIRST MIDDLE LAST Charles Fuller Stevens						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Childs																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 218-12-6197				17. INFORMANT ADDRESS 412 Baldwin Park Dr. Apt A1 Virginia Stevens Westminster, Maryland													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																							
PART 1 DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) Cardio-pulmonary failure 425																							
DUE TO, OR AS A CONSEQUENCE OF																							
Cor Pulmonal 415																							
DUE TO, OR AS A CONSEQUENCE OF																							
Artiosclerotic cardiovascular disease																							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Occipital and basilar skull fracture, intra cranial hematoma																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. Dec. 6 1979						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) fell at work, struck head											
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) car sales						21f. LOCATION STREET CITY OR TOWN COUNTY STATE Carroll Cyt Motors Westminster Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE Harold R. Tritch, Jr.						TITLE (SPECIFY) M.D. deputy						DATE SIGNED May 29, 1980											
EXAMINER'S NAME (TYPE OR PRINT) Harold R. Tritch, Jr. M.D.						ADDRESS 138 E. Antietam St., Hagerstown, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE June 2, 1980						23c. NAME OF CEMETERY OR CREMATORY Pike Creek Cemetery						23d. LOCATION CITY OR TOWN COUNTY STATE New Windsor, Carroll, Md.					
24. FUNERAL DIRECTOR H. Ehlhardt						ADDRESS Wings Mills, Md.						25a. DATE BY RE JUN 3 1980						25b. SIGNATURE					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF A DELAY IS NECESSARY, IT SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF A DELAY IS NECESSARY, IT SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF A DELAY IS NECESSARY, IT SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13866	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) David Lee Stouts						2a. DATE KNOWN OF DEATH May 24 1980		2b. HOUR 6:00 PM			
3. SEX male	4. RACE cauc.	5. DATE OF BIRTH July 22, 1948	6. AGE (IN YEARS) 31 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD May 24 1980		2d. HOUR 6:00 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital (DOA)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. STATE Maryland			13b. COUNTY Frederick		13c. CITY OR TOWN Brunswick	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS "C" Street			
14. FATHER'S NAME (Step) Howard Lester Ingram					15. MOTHER'S MAIDEN NAME Mary Patricia Stouts						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 215-42-3972		17. INFORMANT ADDRESS Route 1, Box 197 Howard L. Ingram - Harpers Ferry, WV 25425						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> E-910 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY 6:00 P.M. May 24 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) drowned while swimming in potomac river						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Potomac River		21f. LOCATION Feeder's Dam Bakerton W.Va						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Harold R. Tritch, Jr.</i>			TITLE (SPECIFY) deputy					DATE SIGNED May 24, 1980			
EXAMINER'S NAME (TYPE OR PRINT) Harold R. Tritch, Jr. M.D.			ADDRESS 138 E. Antietam St. Hagerstown Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/28/80		23c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery		23d. LOCATION Samples Manor, Wash., Md.				
24. FUNERAL DIRECTOR NAME Robert L. Spencer			ADDRESS P. O. Box 446		25a. DATE REC'D. BY REGISTRAR JUN 2 1980		25b. REGISTRAR'S SIGNATURE <i>Harold R. Tritch, Jr.</i>				

BP

DMMH - 17  
(VR A15 ME (5))  
15M7/77



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8013867			
1. FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
Ward Aguston Struckman			May		23		80		10:15A				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		April 13, 1916		61 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				Washington MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Washington County		Laborer		Aircraft							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Washington		Clearspring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD-2					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Aguston		Lillian Diehl											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
No		217-10-6030		Mrs. Arbutus Struckman Clearspring									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
410- <u>hypertension</u>										hours			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb.</u> 19 <u>79</u> , to <u>May 23</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>May 23</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Gloria F. Pura</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5/25/80</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
GLORIA F. PURA		352 S. CLEVELAND		HAGERSTOWN									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		May 27, 1980		Cedar Lawn		Hagerstown, Wash. Md.							
24. FUNERAL DIRECTOR <u>Donald E. Thompson</u>		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE									
Thompson Funeral Home Clearspring, Md.		JUN 7, 1980		<u>Kurtz</u>									

Wm. H. H. H. H.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 3 8 6 8  
CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ANNEBEL L. TILLET</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 22, 1980</b>	
3. SEX <b>FEMALE</b>		2b. HOUR <b>9 50 P.M.</b>	
4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 16 1942</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASH, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD.	
10. CITY OR TOWN OF DEATH <b>WILLIAMSPORT</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOMEWOOD RETIREMENT CENTER</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>GOVT. AUDITOR</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>FREDERICK</b>	
13c. CITY OR TOWN <b>BURKEYSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>BOX 33</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN WILLIAM TILLET</b>	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ISABELLA DEAN AUGHERTON</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>216-46-1057</b>		17. INFORMANT ADDRESS <b>2750 VA. AVE WMSPT, MD 21795</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>coronary arteriosclerosis</b> (c) <b>generalized atherosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>yes</b> <b>yes</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec</b> , 19 <b>77</b> , to <b>5-22</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>5-22</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Harold R. Titch Jr</b>		22c. DATE SIGNED <b>5-23-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAROLD R. TITCH JR</b>		22e. ADDRESS <b>138 E. ANTICRAM ST Hagerstown, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5/27/80</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MONICA 7</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Beallville MONTG. M.D.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. Hilt</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1980</b>	
ADDRESS <b>Barnesville 704</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

May 22 1950

Ticket

Arrival

From Washington  
to New York  
via Philadelphia  
on May 22 1950

Washington to New York

via Philadelphia

Arrival New York  
May 22 1950

Departure New York  
May 23 1950

Arrival New York  
May 24 1950

Departure New York  
May 25 1950

Arrival New York  
May 26 1950

Departure New York  
May 27 1950

Arrival New York  
May 28 1950



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

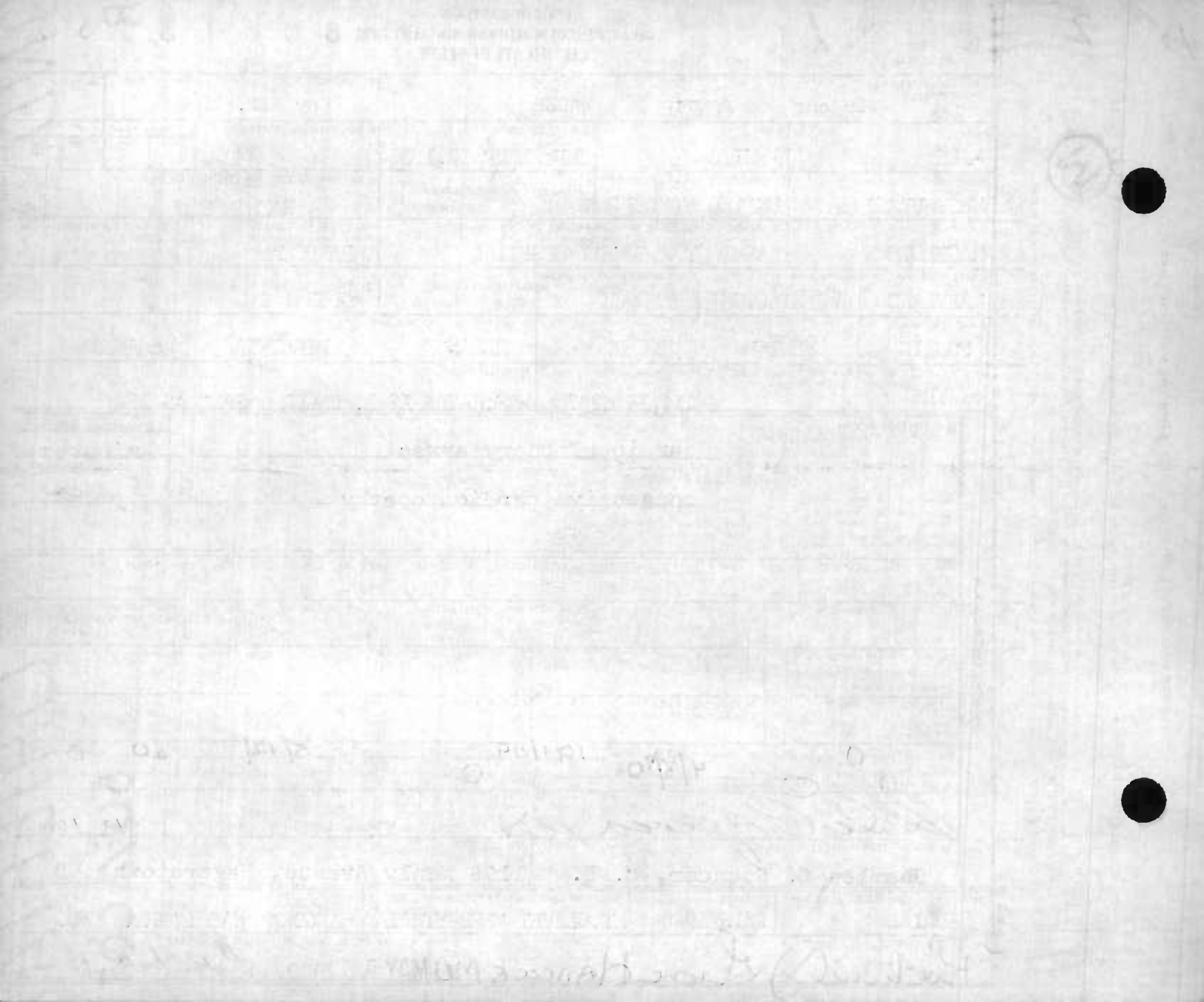
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M7/77  
(VRA 15(4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR CERTIFICATE OF DEATH									
REG. NO. 8 0 1 3 8 6 9									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eugene FONZIE UNGER						2a. DATE OF DEATH MONTH DAY YEAR May 12, 1980		2b. HOUR M	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 27, 1935		6 AGE (IN YEARS LAST BIRTHDAY) 44 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.			
10 CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HEARDSMAN		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND 13b COUNTY WASHINGTON 13c CITY OR TOWN HANCOCK						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS ROUTE # 2	
14 FATHER'S NAME FIRST MIDDLE LAST FONZIE NEWTON UNGER				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELEANOR VIRGINIA McMANUS					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 34 0287		17. INFORMANT ADDRESS MRS. WANDA A/ L. UNGER SAME AS 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 4254 DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive cardiomyopathy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>5 years</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>10/1/79</u> 19 <u>80</u> , to <u>5/12/80</u> 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>4/8/80</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Charles C. Spencer, MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 5/16/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles C. Spencer, M. D.				22e. ADDRESS 1198 Kenly Avenue, Hagerstown, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/15/1980		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET PRESBYTERIAN		23d. LOCATION CITY OR TOWN COUNTY STATE HANCOCK WASHINGTON, MD.			
24. FUNERAL DIRECTOR NAME <u>Richard D. Lane Hancock MD</u>				45a. DATE REC'D. BY REGISTRAR MAY 26 1980		25b. REGISTRAR'S SIGNATURE <u>Peter H. Pender</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

DHMM-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 1 3 8 7 0		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Thelma Catherine VIMONT				2a. DATE OF DEATH MONTH DAY YEAR May 29, 1980		2b. HOUR M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 21, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 673 Oak Hill Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph McKnight				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace (unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 541-22-7452		17. INFORMANT ADDRESS San Antonio, Texas 78239 William J. Vimont, 8002 Hickory Forrest,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Renal Failure</u> 1729 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Metastatic Melanoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Stacey</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/2/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE June 2, 1980		23c. NAME OF CEMETERY OR CREMATORY Broadfording Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR JUN 6 1980		25b. REGISTERED <u>Stacey</u>			

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Benjamin Franklin  
1706-1790

John Adams  
1735-1826

TO HOSPITAL-SEE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 3 8 7 1			
Charles Newton White Sr. <b>CERTIFICATE OF DEATH</b>				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Charles N. White Sr.				2a. DATE OF DEATH MONTH DAY YEAR May 26, 1980				2b. HOUR M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 14, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Railroad			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Sharpsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route # 1 Box 106-A	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Newton White				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth (Unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 705-10-4675		17. INFORMANT ADDRESS Charles N. White Jr. 129 John Street Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY 4292 IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gangrene of Intestine</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 77 to 5/26 19 80, that (I) (most) last saw the deceased alive on 5/26 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
23a. SIGNATURE George C. Newman Jr. M.D.				DEGREE Ph.D., M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				23c. DATE SIGNED			
23b. PHYSICIAN'S NAME (TYPE OR PRINT) George C. Newman Jr. M.D.				23d. ADDRESS 1825 Howell Road, Hagerstown, Maryland 21740							
23e. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23f. DATE 5-28-80		23g. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23h. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington County Md					
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md.				25. DATE REC'D. BY REGISTRAR MAY 28 1980		25. REGISTRAR'S SIGNATURE [Signature]					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8013872		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Kermit S Whitlow			2a. DATE OF DEATH MONTH DAY YEAR May 28 80			2b. HOUR 3:30 PM			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Aug 29 67		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calton Villa Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hospital Attendant		12b. KIND OF BUSINESS OR INDUSTRY Hospital			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Cascade		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Edward Whitlow			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Frances Harding			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown			
16b. SOCIAL SECURITY NO. 213-65-2719			17. INFORMANT ADDRESS Esther Whitlow, Rt. 1 Box 37 I, Cascade, MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 496- Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) COPD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few min yes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Hypertension, vascular Dilean									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3-24-1980, to 5-28-1980, that (I) (we) last saw the deceased alive on 5-20-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Vasant Datta MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-30-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VASANT DATTA, MD		22e. ADDRESS 1600 OAK HILL AVE, HAGERSTOWN, MD 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-31-80		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Maryland			
24. FUNERAL DIRECTOR NAME Gerald N. Minnich		ADDRESS 305 N. Potomac St. Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR JUN 4 1980		25b. REGISTRAR'S SIGNATURE Rising Authority			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy Mae Williams</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 1 1980</b>		2b. HOUR <b>8:35 P.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 17, 1914</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County, MD.</b>				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerical</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance Title service</b>						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>W. Va.</b>		13b. CITY OR TOWN <b>Berkeley</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13d. STREET ADDRESS <b>Lost Road</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest J. Miller</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha --- Westbrook</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>234-01-6604</b>		17. INFORMANT ADDRESS <b>Edmond S. Williams-Martinsburg, W.Va.</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONITIS</b> <b>430-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>INFARCT OF LEFT CEREBRAL HEMISPHERE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>RUPTURED ANEURYSM, LEFT MID. CEREB. ARTERY</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 6, 1980</b> to <b>MAY 1, 1980</b> , that (I) (we) last saw the deceased alive on <b>MAY 1, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Edward B. Byrd M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1 May 80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD B. BYRD M.D.</b>		22e. ADDRESS <b>1190 MT. AETNA RD. HAGERSTOWN MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 4, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Martinsburg Berkeley W.Va.</b>						
24. FUNERAL DIRECTOR NAME <b>Charles M. Brown</b> <b>Brown Funeral Home, Inc. Martinsburg, W.V.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 13 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Barbara K. Cressy</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8013874			
1. FOR STATE REGISTRAR		REG. NO.											
3. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Vernie Virginia WILSON								May 27, 1980					M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. YEARS LAST BIRTHDAY		8. IF UNDER 1 YEAR		9. IF UNDER 24 HRS	
female		white		March 12, 1906		74		YRS.		MONTHS		OAYS	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		11. CITIZEN OF WHAT COUNTRY?		12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		13. BALTIMORE CITY OR COUNTY OF DEATH		14. WASHINGTON		15. MD.			
16. CITY OR TOWN OF DEATH		17. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		18. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		19. KIND OF BUSINESS OR INDUSTRY		20. HAGERSTOWN		21. WASHINGTON COUNTY HOSPITAL			
22. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		23. STATE		24. COUNTY		25. CITY OR TOWN		26. INSIDE CITY LIMITS?		27. STREET ADDRESS			
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		300 Fridinger Avenue					
28. FATHER'S NAME		29. MOTHER'S MAIDEN NAME		30. FIRST		31. MIDDLE		32. LAST		33. FIRST		34. MIDDLE	
Clarence Milton Roser		Maggie Fannie											
35. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		36. SOCIAL SECURITY NO		37. INFORMANT		38. ADDRESS		39. No		40. 220-26-0488		41. Charles E. Wilson, Hagerstown, Md.	
42. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOVASC DYST</u> <u>586-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>GI hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>renal failure</u>		43. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
44. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
45. MEDICAL CERTIFICATION		46. DATE OF OPERATION		47. CONDITION FOR WHICH OPERATION WAS PERFORMED		48. AUTOPSY?		49. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		50. YES <input type="checkbox"/> NO <input type="checkbox"/>		51. YES <input type="checkbox"/> NO <input type="checkbox"/>	
52. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		53. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		54. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		55. 5/10/80		56. 5/27/80		57. 19		58. 19	
59. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		60. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		61. LOCATION STREET CITY OR TOWN COUNTY STATE		62. 1825 Howell Rd Hagerstown		63. Dargan, Wash., Maryland		64. STATE		65. 19	
66. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death		67. SIGNATURE <u>[Signature]</u>		68. DEGREE		69. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		70. DATE SIGNED 5/29/80		71. 19		72. 19	
73. PHYSICIAN'S NAME (TYPE OR PRINT)		74. ADDRESS		75. BURIAL, CREMATION, REMOVAL		76. DATE		77. NAME OF CEMETERY OR CREMATORY		78. LOCATION		79. STATE	
U. D. Wooster		1825 Howell Rd Hagerstown		Burial		May 30, 1980		Samples Manor Cem.		Dargan, Wash., Maryland		Maryland	
80. FUNERAL DIRECTOR NAME		81. MINNICH FUNERAL HOME		82. DATE REC'D. BY REGISTRAR		83. REGISTRAR'S SIGNATURE		84. JUN 2 1980		85. [Signature]		86. 1980	
415 E. Wilson Blvd., Hagerstown, Md. 21740													

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR		
Kenneth Eugene Wink						May 24 1980						5:20		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
male	cauc.	Feb. 26 1946	34			May 24 1980						5:20		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Penna.			U.S.A.						Washington Co. MD					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown			Washington Co. Hospital			Welder								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13d. STREET ADDRESS					
Md.			Washington			Smithsburg YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			R. D. #2					
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST						FIRST MIDDLE LAST								
Holland C. Wink						Lelia Crum								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
Yes						Vietnam			164-36-5688			Mrs. Beverly Calimer 129 W. Second St. Waynesboro, Pa.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a)												2 hrs		
8151 Crainiocerebral injury N-854														
DUE TO, OR AS A CONSEQUENCE OF														
Motor vehicle-fixed/moving collision E-815														
(b)														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
				3:30 PM May 24 1980				passenger in an auto accident						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION						
				road				U.S. 11 W.Va. nr Williamsport Wash. Md.						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED						
Harold R. Tritch, Jr. MD				deputy				May 24, 1980						
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS										
Harold R. Tritch, Jr. MD				138 E. Antietam St. Hagerstown Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				
Burial				5/28/1980		Green Hill Cemetery				Waynesboro Franklin Penna.				
24. FUNERAL DIRECTOR				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE		
David J. Gooch				50 S. Broad St. Waynesboro, Pa.										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80	13876		
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
MARY Iva		WOLF		KILL				5		15	80	3	1 AM
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		May 28, 1899		81		YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				Washington						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Washington County		Home		Home							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Washington		Hagerstown		YES <input type="checkbox"/> NO <input type="checkbox"/>							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Norman		Eliza J. Myers											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
No		160-16-9753		Mr. Frank Nield		Hag. Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Acute Stroke Syndrome</u>										4 days			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Brain Syndrome</u>										4 year			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Arteriosclerosis</u>										? years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from 4/1/80 to 5/15/80, that (I) (we) last saw the deceased alive on 5/15/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Dalton M. Welty, M.D.		DEGREE		22c. DATE SIGNED 5/15/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
DALTON M. WELTY		71 e. yon town, Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		May 17, 1980		Rose Hill		Hagerstown Wash. Md.							
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Thompson Funeral Home		Clearspring, Md		MAY 22 1980		Dalton M. Welty							

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8013877																
1. FOR STATE REGISTRAR			REG. NO.																							
1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH			MONTH			DAY			YEAR			2b HOUR		
Carrie Agnes Yeakle												5			22			80			730 <sup>PM</sup>					
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS											
F			W			8 2 00			79 YRS			MONTHS			DAYS			HOURS			MIN					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH												MD					
Maryland			U.S.A.						Washington																	
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																	
Hagerstown			Washington County			Retired			Home																	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS											
Maryland			Washington			Clearspring									160 Main St.											
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME																							
Lewis			Daugherty			Laura			Shank																	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS																	
No			214-09-4811			Mr. Robert Bowman			1044 W. Wash. St.																	
						Hag. Mr. 21740																				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			1509			Esophageal Carcinoma with			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			17 months														
DUE TO, OR AS A CONSEQUENCE OF			(b)			Osseous metastases																				
DUE TO, OR AS A CONSEQUENCE OF			(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																				
			19																							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE																				
22a. I certify that (I) (this hospital) attended the deceased from 5/1/80 to 5/27/80, that (I) (we) lost saw the deceased alive on 5/27/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																										
22b SIGNATURE			DEGREE			22c. DATE SIGNED																				
Frederic H. Kass MD			ATTENDING PHYSICIAN			MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>																				
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS																							
Frederic H. Kass MD			1825 Howell Rd Hagerstown Md																							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE																	
Burial			May 30, 1980			St. Pauls			Clearspring, Wash. Md.																	
24 FUNERAL DIRECTOR NAME			25. FILED BY REGISTRAR			25. REGISTRAR'S SIGNATURE																				
Donald E. Thompson			1580																							
Thompson Fun Home Clearspring Md																										

1881

1881

Wm. L. Thompson

## MEDICAL CERTIFICATION

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(VR A15 ME (5))  
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